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ORIGINAL ARTICLES.

SUMMER DIARRHŒA IN CHILDREN.

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No department of medicine requires more thorough study and constant attention than this. How quickly, if the least opportunity offers, our patient slips away. No disease removes more children from our midst. Scarletina may sweep away more in a given epidemic, but it is not so constant. When the epidemic passes it seldom occurs again in the same locality for years; whilst every summer brings with its hot and sultry days of July, diarrhœa which often remains with us until October.

Depending upon no special contagion for its prevalence; relying upon no previous attack for immunity against another even the same summer, it is more to be dreaded, both from its insidiousness and constancy. No country, town or locality escapes it, indeed, hardly an individual escapes its sudden attacks, though the very old or young are the only ones in which fears are entertained as to consequences. What other disease is there that knows no bounds, owns every locality, claims so many victims each year and is given so little attention?

No disease has a greater multiplicity of exciting causes. Atmospheric changes, errors in diet, exposure, confinement to house, in fact, we might say any change favors its development.

Too little stress is laid upon this condition. Mother's are led to think the child's case needs but little attention other than care from exposure or change in diet. This may be good treatment at the hands of a physician but, as a rule, for mother's

to follow alone, unaided by other advice—as an idea for physicians to advance to the laity—it is dangerous.

I do not wish to be thought an alarmist in this direction, nor would I have you say to every mother that her child has cholera infantum for the purpose of making a remarkable cure, or shield yourself in case of neglect or oversight.

I am constrained to think the larger portion of cases are the results of errors in diet, *i. e.*, in the younger class of patients. A complicated feeding-bottle is a very dangerous thing in the hands of a nursing infant. A common four-ounce bottle of the shops, armed with a small, black rubber nipple is the best suited as a substitute for a mother's breast. The nurse should wash it thoroughly every time used. In the use of this size bottle, the danger of over-feeding is lessened; the food is brought fresh every time and the habit of having a large, half-filled bottle lying in the carriage or a cradle is obviated.

Many babies are overfed, yet if they cry of stomach-ache they get another meal. After a few days of this there comes the resulting hyperemia, indigestion, catarrh, diarrhœa (summer or otherwise)—cholera infantum. It often depends upon the attending physician as to which of these diseases is applied to the poor sufferer, and often it makes no difference, the result is for the bad. Many times if the bottle, the great exciting cause, were removed, the result would be a complete cure without other treatment.

A few cases are predisposed to catarrhal disorders, and their ills will be catarrhal in nature. Fewer still there are, yet they do exist, who are affected through the nervous system, either directly or sympathetically, and when undue excitement or nervous strain is brought to bear, the bowels are the first organs to give warning.

The child with thin features, large eyes, long neck, pale flabby skin presenting a bluish tinge, predisposed to glandular diseases; one with a scrofular habit, is particularly susceptible to diarrhoea.

The subject of treatment is the all-absorbing thought. We know the cause, locations, and all else; but if unable to cure, we might as well be ignorant of all.

There is much confusion and contradiction in the journals as to the treatment of this disease. In almost every State, county, or town, there is difference in treatment. Indeed, every physician has his own specific or pet fad, and all is so susceptible to change, that one following would have to change every day. This, together with the food of proprietary medicines and foods constantly advertised in the journals, left at your office, with the recommendations of college professors appended, makes the chances of the patient exceedingly hazardous, if used.

I have often thought that in our eagerness to accomplish the very earliest cure, we too often depart from the old, rational line of reasoning in our chase after rainbow specifics, hence in my treatment, I shall endeavor to prescribe in a fashion that can be reasonably defended.

First, we see those, most of all, who are merely suffering from laxness. The secretion seems healthy enough, yet the excretion is thin and frequent—no pain—no weakness, leastwise not for many days. In these cases some mild astringent, combined with tonics, will be sufficient, as bismuth and nux vomica.

I think next frequently, and perhaps most so, we find the diarrhoea of indigestion, gastric, intestinal or otherwise. To this you can give your best and every thought, and often with small success.

In this form we find the greatest number of changes in the stools; all colors and shades. In correcting this condition success lies in the ability of the attending physician to determine the locality of the indigestion. If it be in the stomach,

pepsin will do much for the relief; but very little benefit will be derived if the indigestion occurs below the stomach.

The liver, if torpid, may be improved by small doses of *mercurius vivus*, (which I like much better than chalk mixture, as it does not deteriorate). Should the liver be very active with a hyper-secretion of all the organs, resulting in copious discharges, green in color, much good is obtained in the use of the rhubarb mixtures. I have used Rhus, Soda and Peppermint; Rhus, Soda, Peppermint, and Opium. When pain was severe in the older patients, a mixture: Rhei tr., Opii tr., Menth. pip. ess., Camphor Spirits, gives best general satisfaction.

The least frequent, and most dangerous to our patients, is cholera morbus, or cholera infantum, with its attending vomiting, pain, diarrhoea, collapse,—death! This, if we treat with any success, must be treated early and understandingly.

What is the lesion? Every secretion seems impaired. The alimentary canal is a veritable sewer into which the liquids of the body are poured, altered, acrid, putrid, almost rice-water discharges, anything but normal. Here we have the chance for the utmost energy. I believe alteratives are here of the greatest benefit to correct these changed secretions. I have used with much success:

R Hydrag. bin. iod. 1-160 grain.
Potass. iod. 1-60 grain.

This is an alterative of great value, especially when the discharges are watery and light in color.

Arsenite of copper is very valuable in this connection. Camphor alone or combined with opium is of great service when there is a threatened collapse. Tonics and stimulants are indispensable. I am partial to Catawba Wine for children's diseases; think it superior to the cereal liquors.

Imp—Well did you get into the Garden of Eden?

Satan—Yes; I took the form of a serpent and finished up the business in short order.

Imp—How did you induce the woman to risk everlasting torment for just one mean little apple?

Satan—I told her it was good for the complexion.—*Life*.

HYDROPHOBIA.

HIRAM CORSON, M. D., PLYMOUTH MEETING, PA.

[CONTINUED FROM PAGE 705.]

HAVE CASES OF HYDROPHOBIA BEEN CURED?

In the Encyclopedia already spoken of and published more than a century ago, the author gives many reputed cures and preventives, every one of which was highly lauded in its day, but only two cases were reported as cured after the paroxysms commenced, and they were cases which, judged by the account of them, might now properly be placed in the pseudo-hydrophobia list.

In 1753, a woman with hydrophobia in consequence of a bite from a dog supposed to be rabid, was blooded to about fifteen ounces on Saturday, and given a two-grain pill of opium every two hours. On Sunday the pill, with sulphate morphia added, having been continued, she was bled twenty ounces. On Monday her swallowing was better and the opium and morphia continued, and twelve ounces of blood taken. By a continuance of remedies she recovered. (Page 277.) This case brought opium into great repute, giving no credit to the blood letting. Both of those means were heroically used after that time for many years, but were finally proved to be of little value.

About the same time, 1753, Dessault, by a cure attributed to mercury, gave that remedy great repute. It was given internally and by rubbing mercurial ointment on the sore and on the arm of that side. It is much used and relied on, but time rolled on and the use of mercury was found to be as inefficient as the other vaunted means.

It is very interesting to read of the heroic efforts which were used with every new medicine or physical means that were spoken of as being efficient to cure. Cold baths are much relied on, and patients were carried to rivers and not only dipped in, but kept in for long times, and held under, sometimes until almost drowned. Arsenic too, was extensively used as well as every quack remedy that had any repute. But all failed to hold the confidence of the physicians and the public.

And so from that time until the present, the treatment has been in the hands of

non-professional people who have their vaunted remedies. The Fry's, Stoy's, Emery's and Vansciver's, and the mad-stone people have the confidence of the people, and physicians are ignored, as they deserve to be, in having confessed to an inability to cure a malady which they have never investigated as they should have done.

IS THERE A PREVENTIVE OR CURE FOR THIS DISEASE?

The experience of two thousand years has proven beyond a doubt to every person who has studied the history of hydrophobia, that cleansing the wound thoroughly with caustic, or even incising it without caustic being afterwards applied, is a perfect preventive against rabies. No, not every person now. People who have institutes, like Pasteur in Paris, Gibier in New York, and C. N. Hewitt at Red Wing, to cure or rather prevent rabies in human beings, and who advertise the world over for persons to come to them, have seen that it is important to go back on their former, strong belief in the preventive means so long successful; so successful indeed that the great veterinary surgeon, Youatt, declared emphatically that the means spoken of, if done at any time previous to the actual development of the disease, would, if properly used, be successful in preventing further trouble. Yes, they not only declare these means not only useless, but oftentimes injurious. What motive inspires them? I need not say—a word to the wise is sufficient. Their acts speak as loud as their words. Despite their boasts Fry, Stoy, Emery and the mad-stone can all show greater success.

ELECAMPANE AS A PREVENTIVE AND CURE.

Judge Richard Watson, after reading my pamphlet on hydrophobia, wrote to me as follows: "Are not many physical diseases brought about or greatly aggravated by mere mental fear or excitement? Your essay seems to point to this in hydrophobia. I remember hearing when a child that elecampane was a cure, or a preven-

tive of hydrophobia. My father had a favorite slut bitten by a rabid dog—he also bit some cattle that were said to have gone mad. The slut was kept chained for about a year and fed on elecampane and milk, then she was loosed and lived to die of old age. I thought it was an imprudent risk, but it showed their confidence in the medicine.”

THE “OLD CHESTER VALLEY CURE” *

*From *Our Dumb Animals*, Boston, July, 1874.

A lady met me this morning, saying “Did you see that receipt in yesterday’s paper for curing hydrophobia?” I had not seen it. “Well,” she continued, “it is just the cure I wanted you to write about two or three years ago—the Old Chester Valley Cure.”

I remember perfectly her anxiety that I should write to the public and proclaim that elecampane and fresh milk is the specific for hydrophobia, and my purpose is to repeat the account she gave me of it.

In her old home in Chester county, Pennsylvania, lived a German named Joseph Emery, who used to be sent for far and wide, when anyone had been bitten by a rabid animal. He went to see his patient carrying something understood to be a root, which he himself dug in the woods. He took a pint of fresh milk from the cow, put his root into it, boiled it, gave it to the patient fasting; made him fast after taking it: gave a second and third dose on alternate days and never failed in effecting a cure. In some way which she had forgotten, his secret transpired and the root was known to be elecampane. So well did he establish the local reputation of his specific, that, in his neighborhood, folks were not afraid of mad dogs.

The intelligence and integrity of my informant are beyond question, and I regret that her love of privacy should prevent her from giving the weight of her name to her conviction that this is an unfailing specific for hydrophobia. The people of Chester county are not a class likely to be misled by superstition, and she is confident that it was a general or universal belief that Joseph Emery never failed to cure or prevent hydrophobia. In one case the spasms had begun before the first dose was given, and the patient recovered. The medical properties of elecampane are very powerful. Milk it-

self is a specific for many poisons, and while the medical faculty know no cure for this terrible disease, we should open every avenue of light to the dark subject. If the disease is one of the imagination, we want a specific to give confidence and cure by the imagination; but this looks like a real cure of a veritable disease.—Jane Grey Swisshelm, in *Pittsbury Commercial*.

Robert Shoemaker, for a long time the experienced head of a wholesale drug house in Philadelphia, has been for about twenty years a strong believer in the protective power of elecampane as a preventive of rabies and has written much on the subject. I quote an article of his published in the *Philadelphia Ledger* years ago. “My attention was drawn to elecampane many years since as a preventive of hydrophobia. The active medical principle of the plant is found in the root and is called *inulin*. This I believe neutralizes the virus. Allow me to give a few instances, where this simple remedy has been used. My nephew, then a small boy, was badly bitten in the face by a dog unmistakably mad. The father of the lad came immediately to the city for advice. We called on an eminent physician, who at once prescribed the plant named. The root was given as hereinafter directed. No symptoms of hydrophobia appeared and the lad, now a hale, hearty farmer, lives to show the scar of the wound in his face.” The physician above referred to, related to me a number of instances in which the remedy had been used and *always with success*. He, in fact, remarked, ‘I never knew it to fail when properly administered.’ I will give you but two cases:

“*First*, Two men living near the city were bitten by the same dog, and within fifteen minutes of each other. The dog was secured and the next day showed unmistakable signs of madness and finally died of hydrophobia. Alarmed for their safety, both men came to the city next day and waited on the physician quoted above. He prescribed elecampane root. One of the men remarked, ‘that is an old woman’s remedy’ and refused to take it. The man returned home and put himself under the care of his own physician, who canterized the wound and gave him medicine to salivate him. On the ninth day he was seized with spasms and died in

agony. The other man took the elecampane and never suffered in the least degree from the dreaded disease.

"Second, A number of cows in pasture were bitten by a mad dog. This coming to the knowledge of those who heard of the elecampane remedy, they thought it a good opportunity to give it a trial. The cows were accordingly separated. To one half the number, the root was administered (in form of decoction) and not one of the cows suffered from hydrophobia; whilst all of them not so treated took the disease and died from its effects, or were shot.

"In quite a number of cases coming under my observation of persons bitten by dogs supposed to be mad, I have recommended the use of the elecampane, and have yet to learn of the first case of hydrophobia resulting from such bite where the root was used. I have, therefore, good reason for confidence in the remedy. Whether after the disease manifests itself it would have a good effect, or any effect at all, I am unable to say. But the antidote is so simple and so readily obtained that it would be almost criminal not to employ it.

"Having said this much allow me to give the mode of using it. To one and one-half ounces of good, sound elecampane root, bruised in a mortar, add one pint of new milk, boil it to half a pint, strain off, and when cold take it at a dose, in the morning, fasting. No food should be taken for three to five hours afterwards. Repeat the dose on the third morning, allowing one morning to intervene, and again on the fifth morning. The above quantity is for an adult. For a child give a proportionate dose, say to one twelve years old, half the quantity."

The editor of the *Ledger* remarked on the above: "It is deemed proper here to express the strong belief that in a great many cases in which hydrophobia symptoms occur, the symptoms are induced by excited imagination and apprehension. Considering the large number of cases of injury from bites of dogs that occur every year and the small number of well authenticated cases reported as hydrophobia, persons who have the misfortune to get bitten may well afford to keep their minds at rest about the matter. Not less than a score of the carriers of the *Ledger* have been bitten by dogs, and some of them several times, but they, having no apprehensions

of hydrophobia, have never developed the symptoms of that disease. It is well, nevertheless to have the elecampane ready at hand."

Such is the statement—scores of times these carriers were bitten, but having no dread of a disease from the bite of healthy dogs, they paid no heed to their injuries and yet no harm came to them. But despite the fact that millions of such cases have occurred and no harm resulted, we are now told by Pasteur, Gibier and Hewitt and other pupils of the Pasteur Institute, that there is danger of rabies from the bite of even healthy dogs, and all who are bitten should come to the Institute; travel at great expense, hundreds of miles, many of them, and leave a good fee, besides, with the Institute. Such shameless frightening of the public should call down on the heads of the trio, the scorn and censure of all *honest, sensible* people.

More testimony in favor of elecampane as a remedy. My long-time friend Wm. H. Johnson, ex-Superintendent of the Bucks County Public Schools, thus writes me: "Many years ago when a school-boy, a case occurred in Buckingham township. Samuel Gilbert had seven cattle bitten by a rabid dog. It was near my home. Samuel had heard of the use of elecampane; got it; had the root boiled in milk, and to six of the cattle the dose was given by drenching them. In the seventh the animal was so refractory, that after making a thorough trial, the attempt was abandoned *solely* on account of the difficulty. This one took the disease and died. The other six were never affected by it. This and other similar circumstances coming to the knowledge of my mother, she procured and cultivated it. I am very familiar with it and have great confidence in it. I would, though, as a means of greater security previously use the surgical remedies in conjunction with it."

A physician, a graduate of the University of Pennsylvania, well known to me, who in conjunction with his practice has a large drug store, recently wrote to me as follows, "I have for 36 years been furnishing a mad-dog doctor with one of the ingredients used by him. It is a confection of opium. He administers it in 3 gr. doses; equal to 1-10, or 1-8 gr. of opium. He uses it with chick-weed and I know not what else. The small doses

of opium are to allay nervous excitement and to make the patient comfortable."

In addition to the mad-dog doctors named already, there was in the early part of the nineteenth century a Dr. Van Sciver living at Somerville, New Jersey, who had a far-famed reputation for curing hydrophobia.

POST-MORTEM APPEARANCES IN THE RABID DOG.

These are of a distinctly negative character. There is an absence of specific changes. The membranes of the brain are generally injected to a variable extent. The longitudinal sinus is filled with dark colored blood. Heart and pericardium generally normal. The most important changes are a dark condition of the blood,

some oedema of the brain and more or less catarrhal alterations of the mucous membrane, especially of the respiratory and digestive canals, and the striking emaciation of the whole animal. In cattle the morbid appearances are often similar to those of the cattle plague. In that disease, as we had it in this county a few years ago, they resembled those of pleuropneumonia. Now do those post-mortem appearances indicate that during life in man they could possibly produce the terrible sufferings spoken of as the invariably attendant on this disease? No! Far from it. Take away the mental anxiety; the disturbance of the nervous system induced by fear, and the suffering, judged of by the effect of such lesions in other diseases, would be that consequent on them in other cases.

COMMUNICATIONS.

EXHIBITION OF A CASE OF AKROMEGALY; WITH REMARKS ON TREATMENT BY DESICCATED THYROID GLAND.*

SOLOMON SOLIS-COHEN, M. D.,† PHILADELPHIA.

This case is brought before the Society in order to exhibit some structural changes not found, or at least not recorded, in every case of akromegaly, and to call attention to the apparently good results of treatment with desiccated thyroid gland.

As full details of the case will be published in the *International Clinics* (in my report of a lecture delivered some time ago to my Polyclinic class), I will be brief in the present instance.

The patient, who is some fifty-two or fifty-three years of age, applied to the Philadelphia Polyclinic about eighteen months ago for relief from an excruciating headache, which had for many months been so intense at times as to prevent his lying down, pressure on the scalp increasing the pain. Attention was at once attracted to the peculiarities of facial structures presented, and further examination demonstrated the characteristic curvature of the back and enlargement of the hands

and feet. Photographs of the patient taken twenty years ago and six years ago respectively, bear out his statement that his features have materially altered within the last four years, although the later photograph shows the beginning of the change.

He has had to enlarge his hat-band twice, and his shoes twice within three years. The shoes are a little longer but much broader than formerly. The hands are broadened rather than lengthened; the fingers not exactly "sausage-shaped," but thick and clumsy. Distortion of the joints is to be attributed to his occupation, and probably antedates the development of the akromegalic conditions. Part of the coarseness of the skin of the hands may likewise be due to occupation. His hands to-day, however, are smaller than when he first came under treatment, as shown by our tracings and measurements, and also by his statement that a pair of gloves bought "some years" ago, and too small for him last year, can now be worn.

The enlargement and projection of the superciliary ridges, the lateral projection

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of the malar bones, the broadening and deepening of the chin, give the face the characteristic lengthened elliptical outline. The great enlargement of the nose; the thickening and projection of the lips; the heavy folds, deep furrows, and somewhat greasy texture of the skin, especially of the forehead; the stiffening and projection of the auricular cartilages, complete the picture. The lower jaw does not, however, project beyond the upper jaw. The teeth are bad. The tongue is thickened and deeply fissured. The voice is deep and has a monotonous quality, the latter only partly attributable to his "boilermaker's deafness." The laryngeal and tracheal cartilages are almost if not completely ossified. The thyroid gland cannot be demonstrated. The forward thrust of head and neck from curvature of the cervico-dorsal spine throws the clavicles well out from the windpipe, leaving a great hollow just above the sternum. The clavicles are enlarged, the scapulæ are enlarged, the ribs are broadened and apparently in contact, and the costal cartilages seem to be ossified. In consequence, although the narrowing of the chest—an apparent lateral compression—and the percussion phenomena show absence of emphysema, it will be observed that his breathing is scarcely at all thoracic. There is an almost inappreciable rise and fall of the clavicles, showing slight vertical motion of the thorax as a whole, and on great inspiratory and expiratory exertion an expansion of one-half to one centimetre can be determined at the nipple line. Breathing is almost exclusively abdominal. This shows, as did my previous case, and some cases of Dr. Dercum's and others, that the disease involves the bones of the thorax as well as those of the extremities.

Our patient is becoming feeble; his muscles are wasting, though as yet electric examination shows only quantitative change.

He has vasomotor phenomena—flushing, occasional vertigo, and polyuria. The urine has been deficient in solids, but has not contained sugar or albumen. We have not, indeed, demonstrated anything abnormal in it. This I attribute, however, to defective methods of examination. I have no doubt that careful chemical analyses will show in the urine the results of altered metabolism. Since treatment with thyroid-powder was instituted the quantity

of urinary water has decreased and the urea-content has risen. Ordinarily the thyroid preparation increases both water and solids. Superficially the diminution of polyuria by a diuretic would seem to be an illustration of the so-called "homœopathic law." A moment's reflection, however, shows the action to be simply a correction of disordered metabolism, through which the production of toxins giving rise to polyuria is diminished. Another result of the administration of the thyroid-powder has been to completely relieve the distressing headache.

At one time, after a long absence from the clinic, he returned complaining of violent sciatic pain. It failed to yield to ordinary measures, but disappeared after recourse to thyroid medication. Five grains of the preparation of desiccated sheep's thyroid exhibited by me to the Society last year was given in capsule every morning.

Upon the somnolence, however, no effect has been obtained. The patient can still go to sleep upon the slightest provocation—indeed, without any. He falls asleep while waiting his turn at the dispensary, and frequently missed appointments through sleeping in his chair over the time set. He says that he can keep awake, however, while at work; but as he can no longer do the hard work to which he has been accustomed, he has not for some time had steady employment.

Dr. Jackson examined his eyes, and found no lesion of the fundus and no error in the visual field. This goes to confirm the view that hemiopia and other visual errors are merely secondary phenomena, due to pituitary enlargement, and that the latter is not necessarily a feature of the pathologic complexus. I am, indeed, inclined to believe that early treatment with thyroid preparations will entirely prevent overgrowth of the pituitary body, embryologic analogy seeming to indicate that it is an attempt at compensatory hypertrophy, ill-directed and baneful only by reason of the altered position of the structure.

A CAR driver in Sheobygan, Mich., has been discharged because it was discovered that she was a woman. The gender is a little perplexing.—*Philadelphia Ledger*.

IF a man would live in peace, he should be blind, deaf, and dumb.—*Ex.*

ACUTE PUERPERAL CELLULITIS AND TRUE PELVIS ABSCESS.*

CHARLES P. NOBLE, M. D., PHILADELPHIA.

It is my purpose in this communication to report my experience with acute puerperal cellulitis and true pelvic abscess, collecting together in one paper the various cases which I have reported from time to time. The time has now come when such a communication will be received in a proper spirit—that is, as a report of conditions carefully observed at the bedside, and therefore as a contribution to scientific medicine. The first whirl of excitement which followed the discovery of the real nature of chronic pelvic inflammatory troubles has passed by. Men are no longer blinded by the prejudices of the era when all pelvic inflammation was regarded as cellulitis. A sufficient time has now elapsed to enable them to recover from the reactionary wave, during the height of which it was believed that all pelvic inflammation was necessarily tubal in origin. Practitioners of medicine are very prone to be ruled by the dogmas of a few leaders in professional thought, and gynecologists are no exception to this rule. During two generations they gave implicit adherence to the dogma of Nonat, Churchill, and Emmet, and during the present generation no less implicit adherence to that of Tait and his disciples. It is now time to accept all the facts in the case whether or not they agree with prevailing theories.

CASE I.—This patient I saw operated upon May 8, 1888, by Dr. D. Longaker, who gave me the following history: Mrs. F., aged twenty-six years, III-para. She was delivered of the third child seven weeks ago, by a natural and easy labor. On the fifth day she had a chill, and chills and fever continued thereafter, also great pain. Dr. Longaker saw her seven weeks after labor, and operated for a clearly defined mass situated mostly in the left side of the pelvis, rising up above the brim of the pelvis and extending from the symphysis pubis to the iliac crest. An exploratory *cœliotomy* showed that both uterine appendages were of normal size, but were somewhat fixed by recent adhesions; “neither right nor left ovary nor

tube formed any part of the mass; these structures could be distinctly outlined apart from it.” Fluctuation was distinct in the swelling as made out by the intra-abdominal finger. A second incision was made above Poupart’s ligament, and about half a pint of pus was discharged. The pus cavity was located in the left broad ligament, and extended between the uterus and bladder into the right broad ligament. The patient made a good recovery, but has borne no children since. This is probably because effectual means were taken thereafter to prevent conception.

CASE II.—This patient was seen at the Philadelphia Lying-in Charity during my service there as senior assistant physician. I am unable to find any published notes of the case. My recollection of its salient points is very clear and distinct. This patient was infected after labor, and after a number of days presented the usual evidences of suppuration, together with the signs of intense inflammation on the right side of the pelvis and in the right inguinal region. A hard mass of exudate formed in the right groin, which could be distinctly outlined by palpation. There was every evidence that this was a case of true pelvic abscess, but influenced by the teaching that all pelvic suppuration is intraperitoneal, an abdominal section was made by Dr. Charles Meigs Wilson, assisted by myself. The uterine appendages were carefully examined, and it was evident that the pus accumulation was entirely distinct from them, and that it was external to the peritoneum. The abdominal incision was closed and the pus let out by an incision made above Poupart’s ligament, near the anterior superior spine of the ilium. The patient made an uninterrupted and quick recovery.

CASE III.—This case I saw in consultation with Dr. Himmelwright, March 2, 1890. The history, as given to me by Dr. Himmelwright, is as follows: The patient had a miscarriage, January 3d, in the second month of pregnancy. One week later, symptoms of pelvic inflammation appeared, and a diagnosis of peritonitis was made. The patient got about by February 1st. After a week, pain was

* Read before Philadelphia County Medical Society, April 11, 1894.

felt in the right inguinal region, and gradually increased in intensity, extending to the lumbar region. After another week (February 15th) she was unable to walk erect and to put her foot firmly on the ground, but had to stoop forward. During this time the temperature remained normal and there were no chills. At times the pulse was slightly accelerated. The pain continued to increase, and, on February 27th, a swelling was noticed in the right lumbar region. March 1st, the temperature rose to 101° F., and the pulse to 120, and there were slight chills. March 2d, I saw her. The temperature was normal, the pulse about 90. The right inguinal region was tender, suggesting, indeed, appendicitis, but there were no symptoms to warrant the supposition. A semi-fluctuant swelling was found in the right lumbar region. The next day this swelling had increased, and a hard mass was felt in the right inguinal region, extending as high as the ribs. The swelling in the lumbar region was opened and two or three pints of pus escaped. Introducing my index finger, it passed around the ilium into the iliac fossa. A rubber drainage tube was introduced, and irrigated daily with a dilute solution of peroxide of hydrogen. This discharge gradually decreased and the tract rapidly healed, closing from the bottom.

It may be asked: "Why is this claimed as a case of true pelvic abscess?" The abscess was undoubtedly situated in the false pelvis on the right side. I had my finger in it. The entire absence of bowel symptoms excludes perityphlitis. The fact that, on examination, the uterus was found movable and the broad ligaments free from exudate—no fixation of the appendages—excludes pyosalpinx. Hence I take it, the abscess was due to the breaking down of an infected pelvic gland situated behind the peritoneum, in the right iliac region.

CASE IV.—This case was in every way similar to the first. I saw the patient in consultation with Dr. Langrehr, five weeks after labor. The perineum had been torn, and was sutured some hours after labor. Septic infection occurred, and for three weeks the temperature ranged between 100° F. and 103° F. During this time there was no pain or distention of the abdomen, or tenderness of the uterine appendages on examination. The perineal

wound became inflamed, however, and the stitches were removed. During the fourth week all the symptoms abated. At the beginning of the fifth week the fever increased and tenderness in the left inguinal region became marked. Purulent matter had been discharged *per vaginam*, but whether or not it came from the abscess which had formed was questionable. On examining the patient five weeks after labor, I found her much depressed, in a typhoid condition, with a swelling above the pubes and to the left. Under chloroform a mass of exudate was felt in the left broad ligament extending between the uterus and the bladder, and plainly palpable above the pubes. My diagnosis was true pelvic abscess. I advised median section for an absolute exclusion of complicating pyosalpinx; then a second incision parallel with Poupart's ligament, to evacuate the abscess. This was done by Dr. Langrehr on the following day. The uterus, ovaries, and tubes were found healthy. The omentum was, in places, densely adherent. The abscess was situated within the broad ligament, and extended upward behind and two inches above the ramus of the pubes. It contained about six ounces of thick pus, which was evacuated by an incision in the left inguinal region, directly above Poupart's ligament. The ultimate recovery was perfect.*

CASE V.†—Mrs. G., aged thirty years, II-para, was delivered January 18, 1893, of a living child, after a normal labor. The placenta was delivered by the introduction of the hand. The following day Mrs. G. had a temperature of 104° F., and was suffering much from pain in the right groin and from tympany. On the night of the 20th, I saw her in consultation. The temperature was 103° F., the pulse 110, and there was marked tympany and much tenderness in the right groin. A striking feature in the case was that, although the bowels were very much distended, the abdominal wall itself was not very tense. The coils of distended bowels could be very plainly observed through the abdominal wall. The bowels had not been moved for four or five days. The patient was put upon quinine, strychnine, and digitalis, and the bowels were freely moved. Vaginal and intra-uterine douches

* The first four cases have been reported in the *Medical News* of August 29, 1891.

† *Annals of Gynecology and Pædiatry*, June, 1893.

of corrosive sublimate were employed, although the lochial flow was not foul-smelling. The patient's condition remained very much the same until the seventh day, when the right broad ligament became infiltrated, so much so as to be plainly palpable above the brim of the pelvis in the right groin, while from below the anterior and right quarter of the pelvis was filled with exudate closely attached to the pelvic wall and displacing the cervix backward into the hollow of the sacrum. This exudate began to disappear about the fourteenth day, and was absorbed very rapidly. Convalescence was further interrupted by a nephritis, possibly of septic origin, and also by severe intestinal pain accompanied by diarrhoea, presumably due to inflammation of the large bowel. This patient was seen in consultation by Drs. Goodell and Parish. She eventually made a good recovery.

CASE VI.—Mrs. H., aged twenty-eight years, II-para, was delivered of her second child in March, 1891, the labor being conducted by a midwife. She was infected and was extremely ill. I saw her with Dr. Leopold five weeks after the labor. At that time she was prostrated, with a rapid pulse, "leaky" skin, chills, irregular temperature—in fact, the classical symptoms of septic intoxication.

On examination the right broad ligament was found indurated and a mass of exudate extending on the right side of the abdomen almost as high as the umbilicus. From the extent of the mass it was supposed that a right pyosalpinx with an intraperitoneal abscess existed; but in view of the puerperal history and the existence of a cervical laceration the possibility of a true pelvic abscess was discussed. A median abdominal incision was made April 16th, and the abdominal viscera in the lower right quarter of the pelvis was found fused by adhesions. The patient took ether so badly, becoming cyanosed while still partly conscious, and the pulse was so weak, that I and the gentleman present were convinced that to attempt the separation of the adhesions, and the evacuation of the pus from above, would result in her death on the table from ether. An unsuccessful attempt was made to reach the pus by an incision made near the anterior superior spine of the ilium without giving more ether. The exploration was not pushed, owing to the patient's

bad condition. The patient was then put to bed and improved for some days. Operation was again proposed and chloroform selected as the anæsthetic, which produced as much cyanosis as ether had done. An incision was now made directly over the broad ligament, the uterus was located, and the index finger was forced into the broad ligament, evacuating several ounces of pus. With rubber drainage a satisfactory convalescence followed.

October 27, 1892, I operated on Mrs. H. to cure a ventral hernia which had formed at the site of the third incision. On opening the abdomen I was surprised to find that the adhesions throughout the right side of the abdomen, which had been universal eighteen months before, had disappeared, except a point of adhesion between the omentum and hernial sac, and another between the omentum and broad ligament. Both appendages were perfectly healthy. This fact demonstrates what was believed when the pus was evacuated, namely, that it was not a pyosalpinx, but an abscess of the broad ligament.

The disappearance of the very extensive adhesions in this case is worthy of record as showing that peritoneal adhesions are not necessarily permanent.

It is of interest to report that during the summer of 1893 this patient was delivered of a living child after normal labor, and that she is at present in good health.*

CASE VII.—Mrs. F., aged eighteen years, was confined May 8, 1893. She had a mild puerperal sepsis and was in bed for two weeks. The following month she was constantly sick, being in and out of bed, suffering with pelvic pain, anorexia, and having more or less fever. (The temperature and pulse I do not know, as I was not in attendance.) She came under my care six weeks after her confinement, and was admitted to the Kensington Hospital for Women. Examination showed a large inflammatory mass in the pelvis, absolutely anchored to the left pelvic wall. She was under observation for two weeks, with the temperature fluctuating between 99° and 102°F., with the general evidences of mild septic absorption, such as anorexia, sweats, chilly sensations, and increased pulse-rate.

* Reported in *Annals of Gynecology and Pædiatry*, January, 1893.

Believing that pus was present in the pelvis, either in the form of a true pelvic abscess or a pyosalpinx, an abdominal section was made on June 26, 1893. The following conditions were found: The uterus was fairly well involuted and was displaced upward and backward by a mass in the left broad ligament. The right broad ligament and the right Fallopian tube and ovary were entirely normal, as was demonstrated not only by touch but by delivering the ovary and tube through the abdominal incision. The omentum was adherent to the anterior face and upper border of the left broad ligament in front of the Fallopian tube. This adhesion was separated. The left ovary and tube were found to be entirely normal; the meso-salpinx being normal, soft, and movable. This was demonstrated not only by touch, but by vision, the woman being in the Trendelenburg posture, so that the entire left side of the pelvis was in plain view. The left broad ligament was very much infiltrated with inflammatory material and firmly anchored to the anterior and left bony wall of the pelvis. Fluctuation was not apparent. It was determined to close the abdomen, and if septic symptoms persisted to open the broad ligament from below. That portion of the omentum which was adherent to the broad ligament was ligated and cut off. A small gauze drain was placed against the broad ligament where the omentum had been separated, so that should pus make its appearance at this point it would find its way out through the abdominal incision.

The patient's convalescence was uninterrupted; the temperature rapidly dropped to the normal, and her general condition steadily improved. The gauze drain was removed, good union of the abdominal incision was obtained, and the patient was discharged from the hospital at the end of four weeks. In the meantime, not only had her general condition very much improved, but the pelvic mass had almost disappeared.

This patient consulted me January 9, 1894, to ascertain the cause of a suppression of menstruation of three months. I found her to be between three and four months pregnant. A careful examination of the left broad ligament failed to discover any evidence of the former cellulitis, the left broad ligament feeling exactly like the right one.

The evidence of the existence of acute puerperal cellulitis as a primary condition in this case is absolute. There was not even a complicating pelvic peritonitis in the ordinary sense of that term, merely a point of adhesion between the omentum and the broad ligament, which was, of course, due to a small circumscribed area of peritonitis. I was able to demonstrate these conditions to a number of physicians who were present, including among others, Dr. Fullerton, of the Woman's Hospital.

What I wish especially to insist upon is that in this case neither Fallopian tube was involved in the inflammatory process, that both were entirely normal. The left Fallopian tube and its mesentery were scarcely even congested. The circumscribed area of peritonitis where the omentum was adherent to the broad ligament was plainly due to the fact that the inflammation had extended directly through the broad ligament to the peritoneum, leading to the adhesion of the omentum. That this is possible has been denied by those who maintain that all pelvic inflammation is due to infection which has spread through the Fallopian tubes. In this case the conditions present were unmistakable.

We thus have seven cases in all of which, except the third and fifth, an abdominal section was made, so that we have the evidence not only of the usual physical examination, but also that obtained from an intra-peritoneal examination. In Cases I., II. IV., and VII., the abdomen was opened and the uterine appendages were examined, and it was demonstrated that they were either free from disease, or at the most, lightly attached by recent adhesions. In these four cases there is not a shadow of a doubt that the disease was in the broad ligament, and that it spread to the ligament directly from the uterus or vagina by way of the lymphatics.

CASE VI. was undoubtedly not a case of pyosalpinx, and I have no question myself that the pus was located in the broad ligament. A carping critic might affirm, that even although it was not a pus tube, that the pus was intra and not extra-peritoneal, and that it was due to suppurative peritonitis. My opinion that the pus was in the broad ligament is based upon the fact that the pelvic exudate was anchored to the anterior and right pelvic walls, and that when I cut down upon the

mass I recognized the uterus and tore through the broad ligament with my finger in front of the Fallopian tube.

The evidence in Cases III. and V. is not so absolute as in the others, and they are included in this list not for the sake of *demonstrating* the occurrence of puerperal cellulitis, as is done by the other cases, but because of their relative bearing upon the subject.

The foregoing cases demonstrate several interesting facts with reference to obstetrics and gynecology:

1. That in the puerperal state, pelvic cellulitis and true pelvic abscess occur as the result of septic inflammation.

2. That inflammation may spread from the vagina or uterus along the pelvic lymphatics to the broad ligaments without involving the Fallopian tubes.

3. That peritonitis can be set up by the spread of inflammation from the broad ligaments to the peritoneum without involvement of the Fallopian tubes.

4. That very extensive pelvic exudate and intra-peritoneal adhesions can be absorbed.

It hardly seems worth while to bring evidence to bear in support of our first proposition, and it would not be called for were it not that a few men of wide experience maintain the contrary. Being able to present absolute evidence in the shape of carefully and thoroughly observed cases occurring in my own practice, I shall not take the time or trouble to make reference to the literature.

What I have said concerning proposition one is equally true of proposition two, which is distinctly proven by certain of the foregoing cases. Case VII. is a beautiful illustration of the fact that a very extensive puerperal cellulitis can be present and yet the Fallopian tubes be entirely healthy. In this case they were scarcely, if at all, congested, and the meso-salpinx was entirely free from infiltration.

The third proposition is likewise proven, especially by Cases IV. and VII. In both of these cases the omentum was adherent to the broad ligament, although the tubes were free from disease. I have no doubt that pelvic peritonitis is usually due to the spread of inflammation from the endometrium through the Fallopian tubes to the peritoneum, but these cases show that this rule is not without exceptions. Numerous other exceptions have come under my ob-

servation. For instance, a short time ago I did a hysterectomy for a fibroid tumor, in which the tumor, being impacted in the pelvis, was adherent to the rectum and posterior pelvic wall, over an area of at least nine square inches, and yet in that case the Fallopian tubes were entirely normal. In several cases of appendicitis I have found the peritonitis to extend to the pelvis, the Fallopian tubes having nothing to do with its occurrence. Moreover, it is a well-known fact, that when small tumors, especially dermoids, become wedged in the pelvis, or become twisted upon their pedicles, that peritonitis ensues. Likewise, that in cases of malignant disease of the abdominal or pelvic organs, adhesions are almost always present. Therefore, it must be admitted that pelvic peritonitis can occur independent of salpingitis.

CASE VI. demonstrates our fourth proposition. In that case the entire right lower quarter of the abdomen was fused together by recent peritoneal exudate, and light adhesions had formed in the left half of the pelvis, yet eighteen months later, when the abdomen was reopened, the entire mass of adhesions had been absorbed, with the exception of a small point between the omentum and right broad ligament, and another small point between the omentum and the hernial sac. Owing to the very extensive character of the adhesions in this case, it is a striking example of the fact that recent adhesions can be entirely absorbed.

Two women of the seven whose cases have been detailed in this report have been delivered of living children since their recovery from the attack of acute puerperal pelvic cellulitis.* The subsequent history of four of the other five women is unknown to me. The fact that two of these women have borne children is of interest because of its bearing upon the question of the relation of pelvic exudates to sterility. As this paper has dealt only with demonstrated facts, I shall merely suggest that the occurrence of pregnancy after the existence of extensive exudates, forming during the puerperal state, is best explained in many cases by the fact that the condition present is a puerperal cellulitis rather than a diseased tube. It is a severe tax upon my credulity to accept the state-

* Since writing this article I have learned that Dr. Himmelwright's patient (Case III.) has been delivered of a living child, after a normal labor.

ment that extensively diseased tubes, more especially pus tubes, can so far recover as to permit the occurrence of pregnancy; and I believe that the true explanation in not a few cases of pregnancy following the recovery from puerperal pelvic inflammation is, that the disease was originally in the broad ligament and not in the Fallopian tube.

In conclusion, I wish to say a few words concerning the relative frequency of acute puerperal cellulitis and inflammation of the Fallopian tubes. I believe as firmly as any one, that pelvic cellulitis and true pelvic abscess are comparatively rare conditions, and that the usual variety of pelvic inflammation is a salpingo-peri-

tonitis. I have not met with pelvic cellulitis except in the puerperal state, and have no reason to believe that it occurs in the non-puerperal state, except as a result of infected wounds of the vagina and perineum. As such conditions are very infrequent, a pelvic cellulitis in the non-puerperal state would be a surgical curiosity.

I have added these remarks lest it might be inferred by the unthinking that I am desirous of supporting the old and abandoned theory of Nonat and Emmet concerning pelvic inflammation. At the same time I am glad to be able to present incontestable proofs of the occasional occurrence of acute puerperal pelvic cellulitis and true pelvic abscess.

TRANSLATIONS.

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

CHLOROSIS WITH MENORRHAGIA.

Dr. Ch. Liegeois (*La Semaine Médicale*, No. 22, 1894) prescribes in chlorosis with associated menorrhagia, the following pill, with advantage:

R	Protochloride, or Sulphate Iron	.2	50 (grs. xxxviiij).
	Extract Hyoscyamus	.1	0 (grs. xv).
	Alcohol. resinous Ex. Hydrastis	.5	00 (3j 3/4).
	Licorice Powder	.5	0 (3j 3/4).

Sufficient for one hundred pills—gelatine coated. Two pills at each meal during the menses and the intervals as well.

TREATMENT OF SYPHILIS.

Prof. Lang (*Gazzetta Degli Ospitali*, No. 26, 1894) though an advocate of the internal treatment of syphilis, recognizes the disadvantages of this method: the difficulty of exact dosage and the dangers of mercurial poisoning. To remedy these inconveniences he employs the following formulæ:

R	Protoiodide Mercury	.1	50 (grs. xxij).
	Extr. Opium	.....	50 (grs. vijsa).
	Lanoline	.....	50 (grs. xxij).
	Sugar Milk	.4	50 (3j 3/4).

Sufficient for fifty pills. One to two per diem.

R	Calomel	.....	50 (grs. xxxvij).
	Extr. Opium	.....	25 (grs. iv).
	Lanoline	.....	50 (grs. xxij).
	Sugar Milk	.....	75 (grs. lv).

Sufficient for fifty pills. One to two a day.

R	Corrosive Sublimate	.....	25 (grs. iijss).
	Extr. Opium	.....	50 (grs. vijsa).
	Lanoline	.....	50 (grs. xxij).
	Sugar Milk	.....	75 (grs. lv).

Sufficient for fifty pills. One to two per diem.

If necessary, he also associates the use of arsenic or the iodide of potash, with these formulæ; also in pill-form, according to the following formulæ:

R	Iodide Potash	.....	10	0 (3ijss).
	Sugar Milk	.....	5	0 (3j 3/4).
	Lanoline	.....	3	0 (grs. xlv).

Sufficient for fifty pills. Three, ten, or fifteen a day.

R	Arsenious Acid	.....	50	50 (grs. vijsa).
	Sugar Milk	.....	.5	50 (3j 3/4).
	Lanoline	.....	.3	00 (grs. xlv).

Sufficient for one hundred pills.

The addition of lanoline, which melts at the temperature of the interior of the body, and the sugar of milk which easily dissolves in the gastro-intestinal juices, provide that no particles of these drugs pass through the digestive tract unaltered, so that one may be certain that the quantity of the drug ingested will be absorbed. Thus exactness of dosage and prevention of poisoning are assured. If one will employ a hypodermatic preparation he warmly recommends, from a long experience, the following:

R	Mercury	.....	.....	.....
	Lanoline, ana	.....	4	0 (3j).
	Olive Oil	.....	6	0 (3jss).

Inject five cems. under the skin of the back every three to four days at the beginning, every five to eight days when the symptoms retrogress progressively, and every eight to fourteen days—not more than twice—when they have completely disappeared. He avoids injections into

*In charge of the Translator, F. H. Pritchard, A. M., M. D.

the nates for fear of wounding veins, producing pulmonary embolism, suppuration, etc. The injection into the skin of the back is made four centimetres to the left of the spinal column where they may be continued in the same vertical line four cms. from each other; thus on one side one may inject from five to six times. The other injections may be given on the opposite side. A radical treatment requires from eight to twelve such injections; recurring forms from four to eight. If more than twelve are necessary then make them in a vertical line, eight cms. from the median line.

TREATMENT OF RENAL LITHIASIS.

In *L'Union Médicale*, No. 37, 1894, the following treatment of renal lithiasis is recommended:

Quiet the pain with one or two injections of morphine. Put the patient into a warm bath for an hour or an hour and a half; repeat this during the day if necessary. In children over five years, the same treatment as adults; if less than five years, warm baths, very hot poultices to the abdomen, or if not relieved a chloroform stupe. If the pain is intolerable, ether or chloroform inhaled to slight anæsthesia. If the stomach is tolerant, a little morphine and belladonna. Cold rectal injections.

SUBACUTE CRISES.—A rigid diet, the benzoate of lithine. At each meal gms. .50 (grs. vijs) of salol. Milk is an excellent article of diet, white meats, spinach, lettuce, much fruit. Eat but little and masticate well. On arising drink a glass of pure water. The patient should drink enough, either during meals or in the intervals, to be able to pass a quart and a half of urine in a day. Avoid constipation. If bowels are irregular, take from a teaspoonful to a tablespoonful of the tartrate of potash and soda in a glass of the liquor from macerated licorice roots. Evacuate the bladder frequently. Exercise which is most agreeable to the patient. When once sweating, have him change his linen and rub himself dry. Avoid taking cold above all things. Alkaline baths once or twice a week.

DRUGS.—Two principal indications: alkaline medication and diuretics.

Alkalies.—The benzoate of lithia, one to two grams (grs. xv-xxx) a day, in two

doses, an hour before dinner and supper. Continue these for ten days of each month, and the remaining twenty days the diuretic treatment. The bicarbonate of soda is much used:

R Bicarbonate Soda.....2 | o (grs. xxx).
Powdered Tartaric Acid.....1 | o (grs. xv).
Calcined Magnesia.....75 | 75 (grs. xij).

Sufficient for one powder. One an hour before each dinner and supper. A glass of milk after the powder.

Oxalic Deposits.—Avoid foods rich in oxalic acid: gooseberries, tomatoes, pie-plant, milk, waters surcharged with gases, and cheese. Order meats, fish; the phosphate of soda, one gram (grs. xv) after each meal and on going to bed. Diuretics. It may be observed that in children which eat too much of soups and boiled dishes to replace them by eggs and milk.

TREATMENT OF PSORIASIS.

Dr. Coffin (*Le Sperimentale*, No. 6, 1894) states that treatment will vary according to the form of the disease.

In cases of moderate severity he removes the scales with alkaline baths, soaps, etc. Then he employs the following:

R Glycerolate of Starch.....
Oil Juniper, ana.....100 | o (3ijss).
Green Soap.....5 | o (8j).
Salicylic Acid.....3 | o (grs. xiv).

Every three or four days the affected spots are washed with warm water and tar soap. Pyrogallie acid or chrysarobin may be used instead.

In diffuse forms with pronounced inflammatory symptoms he employs, with advantage, prolonged baths—for five to six hours—and applications of mild salves.

In cases with limited eruptions he employs Vigo's plaster.

In obstinate cases he removes the scales and applies the following salve:

R Ichthyol.....
Salicylic Acid.....
Pyrogallie Acid.....aa. 2 | o (grs. xxx).
Vaseline.....
Lard.....
Lanoline.....aa. 30 | o (8j).

The patient should be well nourished and avoid coffee, alcohol, tea, etc. Arsenic is only indicated when the disease has ceased to progress.

A woman can walk and a woman can talk,
And fritter away a whole day;

But with all of her folly she can't jump a trolley,

Because she ain't built that way.

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SATURDAY, MAY 26, 1894.

EDITORIAL.

A CORDIAL INVITATION.

Two years ago the American Medical Association met in Detroit, last year the meeting place was Milwaukee, and this year the Association will enjoy the hospitalities of the profession of the Pacific coast, during its session in San Francisco. Since for three consecutive years the meetings have been held in Western cities, it would seem to be in the natural order of things for the meeting of 1895 to be held in some Eastern locality.

In anticipation of this probability the REPORTER has called the attention of the citizens of Asbury Park, N. J., to the desirability of securing the meeting of the American Medical Association for 1895, for that city. A year ago, at the suggestion of the REPORTER, Asbury Park extended a similar invitation to the Association, but for sufficient reason an invitation from San Francisco was accepted. The invitation to become the guests of Asbury Park will again be extended to the Association, and there are many reasons why it should receive the most favorable consideration.

Very briefly stated, we may say that

Asbury Park is located on the northern coast of New Jersey, about midway between New York and Philadelphia, and within easy communication of these two cities, the greatest medical centres of America. It is essentially a health and pleasure resort. It is the greatest, cleanest, healthiest; the most attractive, most desirable and most popular of all the health and pleasure resorts on the Atlantic coast. Its facilities for the entertainment of large numbers of visitors are superior; its numerous hotels being fully equipped with all modern conveniences, enable it to handle with ease the influx of three score thousand or more visitors, who from year to year make it their summer home.

The desirability of the place for the meeting of large bodies of men is sufficiently indicated by the fact that during the coming summer there will be held at Asbury Park, the annual meeting of the National Editorial Association, and, in the height of the season, the many thousands attendant upon the meetings of the National Educational Association will be the guests of the city. Other conventions

also will be assembled there during the coming summer.

Among the conveniences of Asbury Park may be mentioned its electric street railways, its water supply from artesian wells, its lighting by electricity and gas, a system of sewerage which is conceded by sanitary experts a model system, and a Board of Health, whose conception of duty is to actively search out "nuisances" of any character and promptly eliminate the same, instead of carefully concealing them.

Of the physical attractions of the place it is not necessary to speak here, save to mention its famous plaza, the greatest and most popular promenade in the new world.

Another point deserving full consideration is the fact that the invitation to the American Medical Association is extended directly by the city authorities, whose assurances are not problematical, and who assume all responsibility for carrying out the details as outlined in the invitation. As a result, this will relieve the local profession of many perplexing conditions, secure concessions which it would be impossible for any body of medical men to obtain from authorities who were but slightly interested, if not utterly indifferent to the possible benefits of such a meeting within their territories.

In the one item of transportation the concessions given at the instance of the municipal authorities may prove a greater saving to the Association than the sum of all concessions otherwise made to its own officials. And where, as in the case of Asbury Park, all business interests combine in extending the invitation, the aggregate of the concessions made will be of great economic value to the Association.

When the REPORTER offered the suggestion, it claimed no authority in the premises and held out no inducements. The citizens of Asbury Park accepted the suggestion and acted upon their own responsibility.

They already have the greatest summer resort for health and pleasure on the At-

lantic coast. They are determined to make it the greatest all-year-round resort in America. To this end they invite the the closest personal scrutiny of their conditions, natural and acquired.

Neglecting no other means of informing the public, they seek to substantiate their claims by affording to all opportunity of proving them by individual experience and observation. Hence they offer the most generous hospitality and entertainment of representative bodies of all kinds, — a policy the wisdom of which has been fully demonstrated in the past.

About Mushrooms.

"*A Guide to the Study of Esculent and Poisonous Fungi*," by Julius A. Palmer, Jr. Lee & Shepard, Publishers, Boston, Mass. \$2.00.

The work is a painstaking effort to point out accurately the difference between esculent and poisonous fungi, and to a great degree must be considered by the medical profession as a valuable text-book. The author upsets the popular theory, among laymen at least, that the changing in color of some fungi indicates their poisonous nature.

"Nothing could be more false. There is one, *Boletus cyaneus*, which turns throughout the most beautiful blue, many that assume this color in lighter shades, and one that turns blood red: this change showing itself wherever the substance is bruised or cut. These are all esculent, while the dangerous *Amanita* remains the purest white under all conditions; that eatable mushroom, the nearest resembling the *Amanita*, may be distinguished by the fact that its gills turn pink or reddish the moment it feels the fire."

Copious extracts from previously published articles are given with the author's comments thereon.

As long as our people persist in the habit of gathering mushrooms(?) basing their ability to distinguish the difference between eatable and poisonous varieties on their knowledge of the characteristic of two or three sorts, just so long will we be in need of authoritative text-books (of which we now have too few) on the effects of each poisonous variety and the proper treatment of the patient.

ABSTRACTS.

NATURE OF PERITONITIS.

At a meeting of the Medical Society of London, the author, Mr. Treves, (*Lancet*, 1894) delivered the first Lettsomian Lecture on the Nature of Peritonitis, which is as follows:

I have ventured to select peritonitis as the subject of these lectures, not only on account of the fact that the diseased conditions known by that name still occupy a terrible prominence among the causes of death, but because the present time appears to be peculiarly convenient for reviewing the clinical and pathological aspects of this fatal trouble, and for criticising opinions which the custom of years has ended with a spurious appearance of accuracy. By peritonitis is understood an inflammation of the peritoneum. From the limited standpoint of morbid anatomy no exception can be taken to this definition; but when it is assumed that the various clinical phenomena which are classed together under the title of peritonitis are due either solely or in the main to an inflammation of the great serous membrane, then the definition becomes to some extent misleading, for peritonitis, clinically as well as pathologically, has comparatively little to do with inflammation of the peritoneum, and it would be erroneous to state that the majority of those who die of what is called peritonitis die of a peritoneal inflammation. Inflammation is by many still referred to as a calamity, as a thing that is violent, as an utter evil, and as an ill-wind that can blow no other than ill, and the measures to be directed against it are commonly considered to be as drastic as those necessary to arrest the progress of fire and pestilence. This view of the inflammatory process needs to be amended, for it is by this process alone that the poison in an inoculated wound is destroyed and the growth of a parasite is arrested. But for inflammation, a man who is accidentally inoculated with a septic micro-organism becomes at once little more than a test-tube prepared for the favorable development and culture of the particular coccus or bacterium; he may be regarded as an organism not far raised above the level of a peculiarly-shaped mass of agar-agar. In a case of tuberculous phthisis it is not the inflammation which

is to blame as the cause of death, but the bacillus which has produced it; the inflammation of the lung prolongs the infected man's life, and his prospects of improvement and recovery depend almost wholly upon it. The "white swelling" of a tuberculous arthritis illustrates the often successful attempt of the organism to rid itself of the tubercle bacillus by means of the inflammatory process, the latter being not a malignant energy working for evil, but a process the object of which is protective, and its end is shown by the freeing of the body from noxious organisms which lead to death. Yet the process may be excessive in individual cases, may be attended by certain disasters, and may fail to some degree in its purpose. It may be assisted and modified by treatment where the latter is directed towards removing the irritants from the tissues. And what has been said of inflammation in general applies equally to inflammation within the great serous cavity of the abdomen; it is an attempt on the part of the organism to avert a too potent cause of death.

The relation of what is clinically known as peritonitis to the inflammatory process requires careful consideration. In the larger number of fatal cases the leading symptoms are those of toxæmia. So far as the clinical aspect of a patient dying from peritonitis goes, he might be dying from snake-bite or from cholera poison, and after death the amount of inflammation discovered is out of all proportion to the phenomena which preceded death. A little injection of the peritoneum, with loss of its polished surface, a little general stickiness with a few frail adhesions, and a scanty mixture of pus and turbid fluid, are often all that is found. This is not the formidable kind of effusion which would be expected in a case of death from inflammation. The larger the dose of poison the quicker is the fatal result and the fewer are the manifestations of peritonitis; this is true both of human beings and animals. Death in the acute cases is said to have resulted from shock caused, in the majority, by profound nerve irritation from the sudden spreading of noxious micro-organisms or their products, over a

wide and sensitive surface. After a smaller dose life lasts for three or four days with symptoms of acute peritonitis, and yet after death the serous membrane shows but the early manifestations of inflammation. In other instances recovery follows after a more or less desperate illness, and this may be effected with or without the development of encysted suppuration. Of course the power of resistance of the individual must be considered as well as the dose of the poison. The favorable cases of peritonitis are usually those in which suppuration is most pronounced, whilst the most acute and unfavorable cases show the least inflammatory changes.

The surgical treatment of acute diffused peritonitis as a purely inflammatory affection by incision and evacuation of the effusion has been comparatively unsuccessful. The mortality attending the operation for strangulated hernia has not greatly improved since the introduction of aseptic measures in surgery, and in cases in which neither gangrene nor perforation of gut occurs, there is something besides mere inflammation which leads to death.

All this is evidence that in the larger proportion of examples of fatal peritonitis the leading symptoms are those of poisoning and not of inflammation; but it must not, on the contrary, be assumed that inflammatory phenomena are wholly subordinate in peritonitis, for in pelvic troubles and in appendix cases the signs of inflammation are paramount. It is obvious that the peritoneum has peculiarities and that there are phenomena attending its lesions which a reference to like disturbances in other serous membranes cannot explain. Suppurations of the pleura have not the same gravity, and this is not explained by the different extent of surface in the two cavities or by a resulting disturbance of function in the viscera covered by the respective membranes. So far as the function of viscera is concerned the visceral disorders in many cases of severe lead poisoning which end in recovery, are more considerable than they are in some examples of peritonitis which end fatally in a few days.

The following points may be noted with regard to the peritoneum:

1. Its surface is probably as great as that represented by the whole integument of the body.

2. It can absorb an amount equal to

from three to eight per cent. of the body weight.

3. It offers a limited resistance to septic organisms and their products, the resistance varying within wide limits and being affected by age and disease.

4. No tissue in the body provides more favorable conditions for healing.

5. It does not show the same degree of vulnerability in all parts, nor are all portions of it alike in the manner in which certain lesions are responded to. The part covering the small intestine is most susceptible; the parietal layer is least so. Localized forms of peritonitis and encysted exudations are comparatively uncommon in the large area occupied by the small intestine and are commoner in the sub-phrenic region, between the dome of the diaphragm above and the transverse colon below, to the outer side of the cæcum and in the pelvis. Extensive inflammation may occur in the hepatic and pelvic regions without inducing very alarming symptoms. Injuries of the intestine are usually fatal, while lesions of the liver and bile passages are commonly slow and moderate.

6. The peritoneum appears to be possessed of great sensitiveness, peculiar and not quite comparable to that possessed by the skin; this is a matter of moment in the production of shock. The sensibility is dulled or lost when the surface is inflamed or covered with lymph.

7. A matter of great interest, though of some obscurity, concerns the condition of pressure within the abdominal area, and the effects which follow the disturbance of it. The cavity of the peritoneum is, of course, a potential space, and the creation of an actual cavity after incision will produce a disturbance of pressure relations which cannot be without effect on the sensitive tissues, and thin-walled blood vessels within the abdominal parietes.

The effect of a mere incision into the abdomen is often very remarkable. To the surprise of the operator, a simple incision into the abdomen in a case of tuberculous peritonitis, followed by evacuation of the fluid, has been succeeded by complete cure, and numerous instances are on record in which simple incision has entirely relieved abdominal trouble; in many of these neurosis as a causative factor of the trouble seems to be out of the question. There are certain other points in connec-

tion with intra-peritoneal pressure which remain to be mentioned. In the first place gravity does not appear to follow the usual lines within the abdomen. In the second place the frequency with which the escapes of feces fails to take place in spontaneous perforation of the intestines, and in punctured wounds of that viscus is somewhat remarkable. Both Travers and Ziegler account for this by the state of intra-abdominal pressure, and Klemm asserts that the idea of the wound in the bowel being blocked up by prolapsed mucous membrane is fallacious.

8. The last point concerns the possibility of the peritoneum acquiring some degree of immunity from septic infection. This condition of immunity can be produced artificially in animals and appears to be possible in the human subject.

Other things being equal, an operation carried out within the abdomen of a person who has had chronic peritonitis or who has exhibited repeated sub-acute attacks, and whose peritoneum presents substantial adhesions, is likely to be attended with better results than when the peritoneum is found to be wholly undisturbed.

In advanced cases of appendix trouble the disproportion which is often noted between the constitutional disturbance and the local condition discovered at the operation, appears to be capable only of the same explanation. In looking over the records of laparotomy performed for perforations in the stomach or bowel, it is impossible not to be struck with the fact that in many of the successful cases, there had been long antecedent visceral or peritoneal trouble.

TREATMENT OF EPILEPSY.

Prof. Lemoine (*Revue Generale de Clin. et Therap.*; Cincinnati *Lancet Clinic*) recommends, in the management of epilepsy, an extensive surveillance, of which the most important points are as follows: The mental diet of the patient should be carefully watched, that he be kept free from all physical and mental exhaustion, psychic excitement, sudden alterations of the temperature, and disturbances of digestion. Alcoholic drinks and coffee are to be forbidden, and constipation to be treated. In the treatment of the attack itself, he recommends a rectal injection containing two grammes (30 grains) of the bromide of potash and chloral, to be administered in the intervals between attacks. If it fail to act after four hours, then give a second one, and even a third, after eight hours. During the attack the patient should be laid either on the floor or a bed and the garments loosened around his throat. In case the seizures rapidly re-occur (he has seen 220 within twenty-four hours), the patient should be placed in a dimly-lit room, and, after cessation of the attacks, it is best to have the patient rest in bed for one day, with substantial but not bulky diet. In traumatic epilepsy he recommends operative interference, while, if it depend upon syphilis, the iodide of potash and mercury are the best means of treatment. For three weeks inunctions of six grammes (1½ drachms) of mercurial

ointment are rubbed in daily, and then the iodide in rapidly increasing doses, from two to eight or ten grammes per diem. After cessation of the attacks the inunctions and the potash salt are continued from one to three months longer and the latter for a year, after each meal. By the use of a great deal of milk the tolerance for these remedies is increased. In menstrual epilepsy he administers every three days ten grains of antipyrine and four grains of the bicarbonate of soda, and as soon as the arterial tension is affected he adds a grain of the powdered leaves of digitalis. If there are, simultaneously, pains in the hypogastric region, he has an enema containing ten drops of the tincture of opium given. In the employment of the bromides the addition of hyoscyamine is of great service. He advises the following combination:

R	Bromide of potash.....	gms. 30
	Bromide of sodium.....	
	Bromide of ammonium.....	aa gms. 15.
	Hyoscyamine.....	mgms. 15
	Water.....	qt 1

If signs of bromism appear he substitutes the bromide of gold for the other bromides, dissolving three grains in sixteen ounces of water. Of this mixture one or two teaspoonfuls per diem may be given. The bromides he always prescribes in watery solutions, and never in syrup. The doses should be large. Borax may be given with advantage in a daily dose of two or three grammes (30 to 45 grains).

THE AMERICAN MEDICAL ASSOCIATION MEETING.

The American Medical Association will meet in San Francisco, June 5th to 8th, inclusive.

The entire work of the Association will be done in Odd Fellows' Building, cor. Market and Seventh streets.

Exhibition room for instruments, pharmaceutical preparations, etc., is also in this building.

Registration will begin in Marble Hall, Palace Hotel, on Monday, June 4th, when all who arrive early enough should register to avoid the rush on Tuesday. Working hours of the Sections will be 9 to 12 and 2 to 5—except forenoon of the first day.

The general assembly will convene at 10 o'clock on Tuesday.

The following hotels have quoted special rates for members and their families: Palace, Grand, Lick, Russ, Occidental, California, Baldwin and Pleasanton.

There will be room for all. Visitors desiring to engage rooms in advance can do so by communicating directly with the hotels, or with R. A. McLean, No. 305 Kearny street, Chairman Committee on Hotels.

Headquarters at Palace Hotel, where there will be a concert in the Grand Court, Monday evening, June 4th.

Tuesday evening a reception will be held at Pioneer Hall, Wednesday evening at Cooper Medical College, Thursday evening at the Midwinter Fair, and Friday evening at the Hopkins Art Institute. The Ladies' Committee on Reception—Headquarters Palace Hotel—will provide entertainment for visiting ladies during the day.

Saturday will be devoted to an excursion around the Bay, starting at 9 o'clock and returning at 5, passing in view of the Irving Scott Ship-building Yards, Spreckles' Sugar Refinery, U. S. Military Posts-Alcatraz, Fort Mason, Presidio, Fort Winfield Scott, and out to the "heads" for a touch of old ocean; returning, pass U. S. Quarantine Station and land at Mare Island, where an hour will be spent inspecting the Government Hospital and reconstruction works.

Railroad tickets will be good for return till July 15th, members will therefore have time to make numerous side excursions in the State, after the meeting. On the S. F. & N. P. Railway, the rate for such

excursions will be a single fare for a round trip.

The S. P. Co.'s rate will be one and a fifth to one and a third fares for a round trip. Some of our seaside and mountain resorts, Mineral Springs and Sanitariums will well repay for time spent on a visit. Among them are Santa Cruz, Del Monte, Santa Barbara, Santa Monica and Coronado; peerless Yosemite and her giant Sequoia forests, Lake Tahoe and Mount Shasta; Paso Robles, Arrowhead, Gilroy Mt., Byron, Soda, Vichy, Geysers, Harbin, Bartlett, and Highland Springs, all possessing medicinal virtues, and justly popular with our own people.

Special inducements are offered at all these places; Paso Robles Hotel offers the best entertainment for members at half regular rates, and Highland Springs, in the "Switzerland of America," with its latch string on the outside, invites members to come and partake of its hospitality, free as the bubbling waters of its springs.

June will be the height of the season for the Alaska excursion, unequaled by any other trip in the world save that to North Cape.

Members who desire to secure accommodations in advance for this trip can do so by applying to the Committee of Arrangements.

Any one desiring to secure space in Exhibition Hall should apply to R. L. Ridgon, Nucleus Building, Chairman Committee on Exhibits.

If members who are getting up excursions will immediately send us approximately the number we may expect from their respective localities, it will simplify our work of preparation for reception and entertainment.

We request also that they will wire us the exact number on departure of their trains.

R. H. PLUMMER,
Chairman.

THE teacher was trying to teach Jones the alphabet. She pointed to the letter X. "What's that letter?"

Jones (bashfully)—"Guess don't know, marm."

Teacher—"O, yes. Think a minute."

Jones (brightening)—"Yes, marm. Dat's daddy's name.—*Boston Globe.*

SOCIETY REPORTS.

THE SURGICAL SECTION OF THE COLLEGE OF PHYSICIANS OF
PHILADELPHIA.*Meeting of April 13, 1894.*

[Stenographically Reported by C. C. Mapes, M. D.]

RADICAL OPERATION FOR CONGENITAL
HYDROCELE IN AN ADULT.

Dr. Thomas S. K. Morton presented a man, aged twenty years, upon whom he had operated six weeks previously for congenital hydrocele of the tunica vaginalis testis. Incision and ligature of the neck of the sac, with subsequent packing with iodoform gauze, was the method of treatment adopted.

The symptoms were: large fluid distention of the right tunica vaginalis; pain and sense of weight; disappearance of the fluid over night and upon prolonged pressure of the scrotum, together with profound melancholy incident to the patient considering himself subject to serious disease of the sexual apparatus.

He was etherized and a four-inch incision made in the scrotum and sac. A probe could then be passed upward through the patulous but very small calibred unobliterated funicular process into the abdominal cavity. A curved needle armed with strong chromicized catgut was passed through the tissues surrounding this sinus beneath the tunic, avoiding the vas deferens and spermatic vessels, and brought out at the point of entrance. When the ligature was tied down tight an effectual approximation of the neck of the sac at the external ring was secured, and all communication with the peritoneal cavity cut off. The sac was then carefully searched for fibrous or other bodies; none being found, the cavity of the tunic was lightly stuffed with iodoform gauze after its edges had been sewn to the skin margins of the wound by a continuous suture.

The packing was renewed every two days. He arose in five days and returned to work, wearing simply a pad of bichloride cotton held in place by a suspensory bandage, in ten days. The wound finally closed, under stimulation by twenty grains nitrate of silver solution, within three weeks. The result, as demonstrated by the patient to the Section, was perfect, and the man had returned also to a normal mental condition.

PICKAXE WOUND OF BRAIN.

Dr. John B. Roberts presented a patient who had recovered from a pickaxe wound of the brain, and said:

"The man was brought to me at the Polyclinic Hospital with a small wound of the skull through which brain substance oozed. He had been struck with a pickaxe shortly before admission to the hospital. Within an hour and a half of the injury I laid open the skull, and found pieces of bones driven into the brain. I used the mallet and chisel to cut away the edge of the fracture, and with forceps removed the fragments of bone from the brain tissue. My finger passed nearly an inch down into the brain structure, which was soft. I then washed away, with a stream of bichloride solution, the soft brain tissue. As there was a good deal of oozing from the pia I stuffed a small piece of gauze into the wound to make a little pressure, sewed up the scalp wound at the ends, but allowed the gauze to stick out at the centre. The patient had union by first intention where the edges were sewn together; and second intention where the wound had been kept open by the gauze, which was removed at the end of twenty-four hours. At the present time the wound is healed and the man well. The pulsation of the brain can be seen where the bony wall is absent. It is four weeks since the accident. If trephining had not been done I believe the man would have died of cerebral abscess."

MISPLACED TESTICLE RESTORED TO ITS
PROPER POSITION.

Dr. Edward Martin presented a case of "Misplaced Testicle," the patient being a boy aged nine years. He had the testicle normally descended on the left side, but on the right side it had gone into the perineum, lying an inch in front of the anus. It was freely movable and normal in size. The difficulty, of course, was, that from its false position the gland was exposed to traumatism. The boy had already suffered from one attack of acute orchitis. The history of these cases of misplaced testicle shows that the gland is at first entirely normal in structure and development; but that it finally, simply from chronic inflammation incident to repeated slight injuries, atrophies and becomes useless; hence the great importance of shifting the still normal testicle to its proper protected position.

The only method to be considered in this case was a free incision, division of adhesion, and replacement. The testicle was cut down upon. The cord was dissected free, some dense fibrous bands passing backward toward the anus and being adherent to the epididymis were cut, an opening was made in the tissue of the scrotum, and the testicle was secured in its proper position by two stitches passing through the lower part of the vaginal tunic and the inner skin surface of the base of the scrotum. The long wound was united in a cross direction, thus deepening the scrotal sac. The wound healed without suppuration, and the testicle lies in a perfectly normal position.

The boy now perfectly well and able to ride a bicycle without discomfort.

PARALYSIS OF LONG RESPIRATORY NERVE OF BELL.

Dr. Martin also reported a case of paralysis of the long respiratory nerve following typhoid fever. During the fourth week of convalescence from typhoid fever it was noticed that the angle of the right scapula became very prominent. This was diagnosed as a dislocation of the scapula—that is, a slipping of the lower angle of the scapula over the fibres of the latissimus dorsi muscle.

On examination it was at once apparent that the serratus magnus was palsied. In addition to its respiratory function the serratus magnus is directly concerned in the movements of the shoulder. By its tonic contraction it holds the scapula, especially its lower angle, closely applied to the chest, and when thrown into full action rocks this bone outward, thus enabling the arm to be carried upward. The deltoid can lift the arm out and up until it is held at right angles to the long axis of the body; the rocking of the scapula by the serratus carries the arm up. Inability to raise the arm higher than the shoulder was well-marked in the case. Under treatment by massage and electricity the patient has recovered in a great measure. He is not absolutely cured, but the outlook is good, as I believe it is in the majority of these cases of neuritis after typhoid fever. The photographs show very perfectly both the disability and the wing-like projection of the shoulder-blade.

CURED FRACTURE INVOLVING THE ATLAS AND AXIS.

DR. M. H. CRYER: This is a specimen of which I do not know the history, except that it was found in a lot of bones when the Philadelphia Dental College was removed to its present quarters. The atlas and axis are held together by bony union. The odontoid process is not in its normal position, but nearly in the centre of the spinal canal of the

atlas. From this, one would judge that in displacement of these bones the transverse ligament had been torn and the patient had lived at least long enough for the bony union to take place, although the spinal cord must have been impinged upon to a very great extent.

NON-RECURRENCE OF MALIGNANT MAMMARY DISEASE AFTER EIGHTEEN YEARS.

Dr. Thomas G. Morton presented a patient, fifty-six years of age, on whom eighteen years ago he had removed the right breast for malignant disease; the tumor, a rapidly growing one, was large and with the usual characteristic symptoms. Since the operation the patient has had no return of the disease, and continues in excellent health.

DEMONSTRATION OF A NEW SURGICAL ENGINE.

Dr. M. H. Cryer exhibited an improved surgical engine, with its various shaped drills, burrs, trephines, and guards, used in cutting bone for surgical operations.

The drills are made with three spiral blades, giving them the appearance somewhat similar to a twist drill. The effectiveness of these blades is enormously increased by a spiral screw, forty-four threads to the inch, cut around the blades of the instrument. This device necessarily adds forty-four teeth to the inch upon the edge of each cutting blade. The individual teeth are so arranged with reference to one another that the cut made by one tooth is overlapped by that of the one next following. These instruments are used for drilling into bone and opening the medullary canal, as in the case of osteomyelitis, or in removing sequestra formed in the long bones. After the bone has been cut down upon and the cloaca found, it is opened up with the spiral drill and by forcing the instrument laterally the side portion will cut the intervening bone away, thus making a groove down on the dead bone. If the opening thus made is not large enough, burrs of various sizes, made on the same principle as the drills by increasing the number of spiral tooth blades in definite relation to the size of the cutting instrument required, can be used to enlarge the groove to any desired size. These burrs are very useful for removing dead or abnormal bone, uncovering nerve canals for operating on the bony structures in relation to the ear, or in the nasal chamber. For the latter work, Dr. Cryer exhibited a lighter engine made on the same principle as the large one, except that it is made to turn by the foot of the operator.

The most important instruments exhibited were those used for making a section of the brain case. These were of two characters, the circular saw and the spiral osteotome.

The circular saw is one inch in diameter and one-sixteenth of an inch in thickness, having a guard attached to the end of the handpiece to regulate the desired depth to be cut. This instrument has been successfully used in an operation for the removal of the Gasserian ganglion. It cuts with great rapidity, but as brain cases vary in thickness, the operation has to be completed with mallet and chisel. The spiral osteotome overcomes this objection, the cutting portion being made on the principle of the drills already described. It is one-half inch in length, one-eighth of an inch in diameter. The point of the instrument when in use is guarded by a rounded button-like attachment connected with the nose of the hand-piece by means of a shank and collar. The free end of the burr is dowelled into a seat in the guard in which it revolves; this steadies the whole instrument when in use, giving added rigidity to the burr shank and holding the burr and guard in permanent relation to each other. The principle involved in the instrument described is simply that of saw cutting in a line with the axis of the shaft of the burr and not at right angles to it as in the circular saw. Such an arrangement allows of cutting in any direction and upon curved lines. This is especially valuable in resection of the brain case, inasmuch as fenestræ of any desired shape or size may be speedily made.

In operating for the removal of a portion of the brain case with this instrument after a division of the soft tissue by the scalpel, an opening five-sixteenths of an inch in diameter is made by a trephine mounted in the engine hand-piece; it is passed completely through both tables of the skull and a button of bone removed. There is no danger of injuring the dura with the trephine if it is carefully used. The opening thus made affords a means of entrance for the osteotome, which, with its protecting guard, is next inserted and the section made along the line previously determined by running the engine at a high rate of speed and forcing the bit laterally in the direction desired. The button-like guard at the point of the osteotome prevents injury to the dura, which is pressed or directed away by it from its attachment in the line of the cut as the instrument progresses.

Dr. Cryer made several demonstrations on the bones and head of the cadaver, showing the rapidity with which bone could be divided, and various operations performed, such as drilling and cutting bone, and uncovering the nerves in the superior and inferior maxillæ. The safety with which the operation in opening the brain case was done without injury to the dura was very gratifying. In conclusion he said: "At a meeting of the Philadelphia County Medical Society, held February 14, 1894, during the discussion of

an operation for the removal of the Gasserian ganglion by Prof. W. W. Keen, in which this engine had, in my opinion, been successfully used, Dr. John B. Roberts made the following remarks: 'With regard to this elaborate instrument it seems to work very satisfactorily, yet for my own work I should rather use a sharp chisel with my own hand and my own mallet than any mechanical device. These are apt to get out of order and must be at some place where they can be kept in order. What we want to do is to train our own hands to do the work, and not to be dependent upon any mechanical device.' This statement indicates to me an erroneous position with regard to this class of instruments, which it seems to me ought not to go uncorrected.

"With all due respect and admiration for the ability of Prof. Roberts, I am a little fearful that surgery would take a back seat if all its mechanical devices were done away with. I heartily agree with him when he says: 'What we want is to train our hands to do the work,' and I would strongly advocate the highest possible attainment of manual skill as a necessary prerequisite in the performance of all surgical operations; but when he adds that we should 'not be dependent upon any mechanical device,' I am inclined to take issue with him on the ground that his statement is contradictory from the very fact that he himself advocates the use of a mechanical device, albeit a very crude one, in the shape of a mallet and chisel. This machine has now been so simplified and perfected that there is little or no danger of its getting out of order. It is not nearly so complicated as the most simple sewing machine, yet men and women run this, and who would say go back to the ordinary needle and do away with the sewing machine?"

DISCUSSION.

DR. L. W. STEINBACH: I have had the pleasure of having Dr. Cryer perform one of these operations for me recently in a case presenting some difficulties from the fact that repeated operation had been performed on the inferior maxillary portion of the fifth nerve, and I was delighted with the working of the engine, so far as the bone-cutting was concerned, but I do believe that the amount of blood lost was greater than at the previous operations, where the ordinary chisel and mallet had been employed. As a mechanical device I can praise the instrument, and I do not wonder that Dr. Cryer is enthusiastic, but I cannot agree with him that it is a great advantage to a surgeon to learn to use such a complicated machine. It might be of much advantage in a hospital where much work is done.

DR. ROBERTS: I was very much interested in trephining with the surgical engine some

fifteen years ago, and wrote an article on the subject after experiments with a flat-headed burr. I am now very fond of the chisel and mallet for opening the skull, using a small sharp chisel shaped like an osteotome.

DR. J. WILLIAM WHITE: I have never had the advantage of seeing this particular instrument used in actual operations, but I can see no theoretical reason why it should not be employed with great advantage to surgeon and patient. I suppose there is no surgeon who does more trephining than Mr. Horsley, of London. I noticed last summer that he employed a powerful electric engine in which he used a burr or saw, and could cut out a section of bone with a great saving of time. It looked to me like a dangerous thing, and it was remarked that there was force enough to drive a part through a man had any portion broken loose. With it, however, he greatly reduced the time required for exposing a brain tumor, did the work with great delicacy and with much less shock (if shock is the result of jarring and concussion of the brain) during the operation than would be inflicted by a mallet and chisel. He, however, cut from without inward. This is the first time I have seen a machine cutting from within outward. We have observed here that it actually pushes away the artery from the bone without injury. I cannot understand why such an operation should be attended with any more loss of blood than by the usual methods, and I do not know why Dr. Steinbach's operation should have been any more bloody. Of course this view is purely theoretical, but as I find a surgeon like Horsley, who is one of the most expert operators on the skull, using a machine which seems to me of distinctly less advantage than that the action of which we have just had demonstrated, I believe this engine has a future especially for use in the hospitals, either for nerve resection through bone or for work upon the brain.

DR. M. H. CRYER: I have not much to say, for the demonstration was the principal part, but I am inclined to answer my friend Dr. Steinbach. I believe, from my experience and the experience of others, that in second, third, or fourth operations on the same part one generally has more hemorrhage, for the simple reason that the small arteries are dilated, small capillaries have become arteries through ligating the primary artery, and are therefore more difficult to control.

As to the engine getting out of order, the liability is very slight. It can be run by a child. It is much more simple than the sewing machine, and I should pity the doctor who cannot use this engine. Of course, every device placed upon it makes it a little more complicated, and it requires study and practice to know how to work it. But if I

had to remove a portion of the brain case I would not think of using any other instrument at the present time.

THE MARRIAGE OF SYPHILITICS.

By Wm. G. Porter, M. D. (See page 699.)

DISCUSSION.

DR. J. WILLIAM WHITE: The general conclusions of Dr. Porter's paper, I think I, in common with all the members of the College, agree with. The three forms he mentions are commonly met with in practice. It is certainly to-day more benign than when many of us began to practice medicine. It is now rare to see the grave variety in which the primary symptoms are soon followed by the tertiary phenomena. If it is true that syphilis is a milder disease than it used to be, it is milder probably in every direction, and we may feel more encouraged than our predecessors to authorize the marriage of syphilitics. It was many years before Dr. Agnew could be brought to say positively that he approved of the marriage of any of his syphilitic patients, and it may be that this slowness on his part was due to the sort of experience with syphilis that we younger men had not had.

It is desirable to formulate some safe rule as to the permission which we are asked to give or withhold in cases of syphilitics intending marriage. Now, the writers who say that as we do not know when a given patient is cured, and as we cannot apply any test which establishes this, we cannot, therefore, give our consent, confuse the future danger of the individual with the possible danger to others, including his offspring. I think it is a confusion which prevails to a certain extent in the profession, and, to a very wide extent in the laity. It is unfortunately true that we are not able to tell a man that he himself will not have further symptoms of syphilis. We may place the percentage of cures very high, and I, myself think, that most of us who treat syphilis intelligently get from 90 to 95 per cent. of cures in the average line of cases. But we cannot select from the 100 cases the five or ten cases that we have failed to cure, and forbid marriage. Nor can we expect to do so until bacteriology has done more for us than it has up to the present. But that has very little bearing, I think, on the question of marriage. Because, as a matter of fact, after a certain time has elapsed, particularly after the combination of circumstances which exist where a patient has had moderate syphilis with efficient treatment, and has gone for a time, two years, say, without symptoms, I think we are very safe in saying there is little danger to others. Personally, I would have the same, but no greater, objection to giving my

consent to the marriage of a man with tertiary syphilis as to that of a man with strongly marked tubercular predisposition, or with mental disease. I think the risk of transmission in the two last named would be far greater than if he had gumma, rupia, or periosteal nodes. I am not aware of any instance, satisfactory to my mind, in which tertiary syphilis has been transmitted either to any individual or to offspring. The reported cases are generally defective in some important point. It is difficult where two persons are concerned, particularly in instances of heredity, to be quite sure that the husband has been the parent, and most reported cases are at least open to error in that respect. There are other sources of error, but as a matter of fact, the impression left on my mind is that there is no case scientifically conclusive as to the transmission of tertiary syphilis. I would therefore dissent absolutely from those who believe that no patient with any form of syphilis should be permitted to marry. A man with tertiary phenomena is not likely to have healthy children, nor is the tubercular patient, but the man with tertiary phenomena is not likely to have syphilitic children. And it is safe to say he cannot transmit his disease. Even the fluid of his gumma, or ecthyma, or of his softening node, cannot be inoculated.

His wife may have an occasional miscarriage, or have a child born dead, just as might happen if the husband had chronic alcoholism, or was in the last stage of any grave constitutional disturbance, but she is not likely to have a syphilitic child. That, I believe is the only point in Dr. Porter's remarks on which I have any criticism to make. I think his general rules are admirable. It will surely not do to say that all syphilitics may not marry, because it would certainly result in ruining many lives. I am personally familiar with a great many cases in which unnecessary dread of syphilis has led to prolonged dissipation or melancholia, or suicide. I am now treating a gentleman who has broken off his engagement with an attractive girl; he has given up his business, and is gradually progressing toward the suicidal stage, because he is of the opinion that no man has a right to marry with this disease. He is morbid, of course, and I think he will probably come out of it. But there has no doubt been a great deal of unnecessary alarm. The rules of Dr. Porter are practically those I have adopted, except that I do not require such a long period of freedom from symptoms. In general figures I tell my patients they must wait four years. But if a man at the end of three years has a slight mucous patch I do not, on that account, make the time five years. For fifteen or eighteen years I have been seeing a great many of these cases,

and I have from the start followed this general rule. Fournier's book was published about 1878, and was the first well-considered work on the subject which came under my notice. I had been appointed a teacher on syphilis in the University, and I practically adopted his rules then, and have never varied very much from them since. He said in effect that syphilis must have been benign; that a period of three or four years must have elapsed; and that the treatment must have been thorough and complete. I say I have never varied much from them, but as time has gone on I have come to place more and more weight on the one element of time, the period that has elapsed after inoculation, and comparatively less upon the thoroughness of treatment and absence of symptoms. And I need scarcely say that in that time there have been a great many patients grown up and married, and had children, and I cannot recall an instance where such marriage was entered into with my consent and approval where anything happened to cause me to regret my action. I do not know a single case where, after four years had elapsed before marriage, there was born a syphilitic child. I think that, after all, is the most important thing to discuss. If it is a safe rule, it is an easy one, and we cannot go far wrong in its application. If it is not a safe rule I shall be glad to hear reasons for considering it unsafe.

DR. EDWARD MARTIN: This subject has been very thoroughly traversed by Dr. Porter, Dr. White, and others. The rules governing it are practically common-sense rules dependent upon certain generally accepted facts: Thus every one grants that a man with syphilis not two years old is liable to give the disease to his wife, and to have diseased children, though this is a rule with many exceptions. It is also granted that a man with syphilis three or four years old is *not liable* to convey or transmit the disease; though this rule has a few exceptions. It is granted that a man with syphilis more than four years old is not necessarily cured, since it is impossible to state positively that late manifestations will not appear, but in so far as conveyance of the disease to others is concerned, he can be regarded as safe. This is a rule with very rare and doubtful exceptions. All the reported cases are open to the criticism of Dr. White. The evidence is, however, rather strong to the effect that the disease can be transmitted to the child when it is impossible to directly infect the wife. Finally it is granted that syphilis is a curable disease, though there is absolutely no sign or group of symptoms which can be taken as satisfactory evidence of cure. Reasoning from these rudimentary and commonly accepted beliefs it would seem perfectly proper

to allow syphilitics to marry after their disease has become non-contagious. Probably after two years of continued careful treatment the disease ceases to be contagious in the majority of cases. Not always, however, and it is proper to err on the safe side. The period of four years is that generally allowed, and I have never known a physician who has seen or heard of a case of transmission after this period. Even after four years marriage may not be advisable, not because a patient has had syphilis, or is liable to infect others, but simply because of debility or cachexia there is little promise of healthy offspring. The ground for forbidding marriage would be precisely that taken in the case of consumption. There is an exception which I have made to the general rule of forbidding marriage until the contagious stage of syphilis is passed. Although marriage, perhaps, had for its cardinal purpose, and has still, the propagation of the species, there are many other reasons why it is entered into. There is the element of association, protection, and mutual interest which can be considered quite aside from the sexual aspect of the case. It happens, I think to almost every one, to see cases of buccal chancre acquired by innocent girls from their affianced. I have never hesitated under such circumstances to encourage marriage, warning the patients thoroughly of the dangers of conception, until at least four years shall have elapsed. With this one exception I believe I am thoroughly in accord with the rules laid down by Drs. Porter and White.

DR. ARTHUR VAN HARLINGEN: The remarks I have to make are based only upon my own personal experience. Any man practiced in this class of disease, if he has kept careful note of his cases, must have a certain aggregation of personal experience; and I think that when we bring this experience together it is of a certain amount of value. When the subject of this discussion was first brought to my notice I began to look up the literature, and found that Fournier's work is practically the only one which could be used for reference. In an article written several years ago I based my observations on the work of another French writer, Lancereaux, which I thought excellent from a practical point of view. Fournier, however, is the only author who has given us statistics upon which we can base any conclusions. Aside from this, I think our individual experience is all we can depend upon. The result of my experience is as follows:

In my opinion, it does not seem proper for a man to marry as long as he has any of the secondary symptoms, though I have known immunity to result even in these cases. In my own experience, tertiary symptoms never prove contagious. The man who marries

with the secondary symptoms runs the risk of conveying the disease to his wife. With tertiary symptoms I cannot recall any cases in which a man has given syphilis to his wife. In regard to the conveyance of the disease to the child, it has been said it is possible for a man who is in that stage in which the lesions are in all probability not contagious to convey syphilis to the offspring, but I cannot remember any cases in which this has been actually reported. I think it would be advantageous, if any such cases exist, that they should be recorded. Fournier records sixty to seventy cases of syphilitics who married at periods extending from nine to twelve months to a number of years. He reports one case in which the man having syphilis married, and after having three or four healthy children, he himself suffered from tertiary symptoms. His wife was not infected. My own experience is this: I have watched a couple of dozen of cases; I have followed some from five to twenty years, and I should not fear any of my patients marrying after the second year, if they have submitted to a regular course of treatment. I have been in favor of the continuous treatment. My custom has always been to wait until the secondary symptoms occur, and treat continuously. I have treated a dozen or twenty cases from eighteen months to three years. I cannot remember any case in which I have authorized marriage after the second year where the disease has been transmitted. I am aware that this is a much shorter time than is allowed. My own experience is that after the second year healthy children can be engendered. Perhaps the standpoint taken by others is a safer one than that I have taken. I think it will not be very long before some such question will come up before one of our courts of justice. It seems to me a question that we can only decide by uniting our experience, and by each person in private practice publishing his own well-recorded cases. And my urgent advice is that those who see such cases should record and publish them. I cannot see any other way of securing proper data.

I remember the case of a young gentleman who showed the late ulcerative symptoms of syphilis, which yielded very quickly to proper treatment. After the ulcerative lesions had passed away he suffered from that peculiar form of myositis resulting in the contraction of the biceps, which yielded some extent to treatment, but not entirely. He always had a certain amount of contraction. After eighteen months of treatment he asked me if I would allow him to marry. I said I would think it over for several months and then give him my opinion. He did not come back for that opinion. But if he had, and if I had given my consent, the case might have

been brought up before the courts. I wonder what my position would have been if this gentleman had married; if I had given him a written opinion that he would in all probability not transmit the disease to his wife nor have a syphilitic child, and then if the worst had happened? What would have been the expert testimony given by my colleagues? I think that if we could get a body of personal experiences by the gentlemen who see these cases, accurately gathered together, we would have something to go upon. There is really nothing in print except this book of Fournier's. If a case, such as I have mentioned to-night, were to come up before the courts, I do not know what I would have to base my opinion on, except what has been said here this evening. I think it is one of those questions in which the members of the college should publish their opinions, and this, I think, would make a body of evidence which would be of use later on.

DR. HENRY W. STELWAGON: I have listened with a great deal of interest to the reading of Dr. Porter's paper and the remarks by the other gentlemen who have spoken. It is a subject, of course, of large importance and far-reaching. It seems to me in a question of this kind an opinion is to be reached only after viewing it in all its aspects and bearings, basing the conclusion upon aggregate observations, and not putting too much weight upon individual experience. There are certain facts upon which I think all observers are fairly well agreed. One is that during the active and early stages of the disease marriage is tolerably sure to be followed by dire consequences. Another is, that under the most favorable circumstances at least two years should have elapsed between the contraction of the disease and the assumption of the marriage state. Another is, that after a variable number of years syphilis tends in almost all cases, and probably sooner or later in all cases, to lose its infective activity and transmissibility, so that finally there remains nothing of a specific character to transmit. This length of time depends doubtless upon several factors; the type of the disease, which Dr. Porter has referred to; the prior and concomitant health of the individual; his mode of life; and last, but probably the most important of all, the character and thoroughness of the treatment. In syphilis of a grave type, those cases which we see from time to time of a more or less malignant character, the greater possibility of present and future risk should not be lost sight of. The same can be said of the disease occurring in strumous individuals and in other persons in delicate health. The syphilitic addicted to the excessive use of alcohol for a longer time, is doubtless an unsafe husband and procreator. The explana-

tion is to be found in the lessened resisting power. With the exception of these several classes, however, I believe that syphilis is not the grave misfortune it has so often been painted. In the average case of syphilis, occurring in a subject of ordinarily good health, living a temperate life, and who has had intelligent treatment, the power to communicate and transmit the disease is probably, with the exception of a few instances, lost in the course of a few years; and even in the imperfectly treated and neglected cases, judging by general experience, the disease would seem to wear itself out in from two to five years. If this were not the fact, the example of hereditary transmission would certainly be much more numerous than observations show them actually to be. It is, however, the uncertain cases, or the exceptional cases I would say, which give us concern and make us hesitate. And such cases, we are informed by the records, may occur in those who have been well treated and carried out all medical directions, and who are or should be presumably entirely free from all contaminating virus. That such exceptions, according to the records, do occur we must all concede; that they are extremely rare must likewise be granted. It has often occurred to me that some of these exceptions are apparent rather than real, that there may have been good and sufficient reasons pointing against marriage, such as an insufficiently long period of treatment, depraved general health, alcoholism; some may also be attributed to faulty observations, as Dr. White has suggested. I believe myself that persons in good health, of good habits, in whom the disease has been of a mild or average type and has run a favorable course, with no tendency to active recrudescence, and whose treatment has extended over a period of two or three years, during the last year of which there have been no manifestations—that such persons may, if three years or more have relapsed since the date of the contraction of the disease, marry without the slightest risk. Such is the conclusion to which my own observations would lead.

If, however, the question of the marriage of syphilitics is to be viewed purely from a strictly scientific and medical standpoint, and thus necessarily taking cognizance of the rare exceptions and recognizing the possibility of disaster, we should probably feel obliged to refuse our professional permission in all cases. But by so doing we would prevent many happy marriages, damage the socially and politically important family life, and tend, moreover, to encourage immoral living. A liberal view of the question, based upon the broad ground of the public welfare and the knowledge that in proper cases the danger is practically *nil*, would not justify us in such a course.

DR. A. B. HIRSH: There is one phase of the subject which has a half-medical, half-popular aspect, that might be appropriate to mention here, and I refer to a point raised in the discussion by Dr. White, that of syphilomania as occurring in some of the chronic cases coming under our care. We are quite well aware that such cases are apt to occur in the intellectual patient, the man who reads, and not in the average or ignorant dispensary class; such individuals would be apt to have this subject laid open to their inspection by novelists who deal with the more material subjects of the day. It is quite interesting in this connection to know that one of the works which has been most widely read recently deals with this very subject, and individuals suffering from this infection and reading the same would perhaps be confirmed in this very serious view of the subject, and be liable to the mania here discussed.

DR. PORTER: Dr. White seemed to intimate that I possibly thought the tertiary lesions were contagious. I had no such thought at all, and put tertiary patients under the ban, not on account of their generally broken down condition of health, which would not justify marriage.

In regard to the time, the rule which I laid down which has guided me for a number of years is to allow two years to elapse after the disappearance of the last syphilitic symptom. The average period of the duration of treatment is about two years, and that would make the duration the time laid down by Fournier, four years after the inception of the disease. Many cases, however, do well in which the treatment is not prolonged more than a year. At the end of that time, after two years have elapsed, that would make the period three years. The time depends on each individual case.

In regard to statistics, Dr. Van Harlingen has well said that the only thing we know of in the literature on this subject has been written by Fournier, and these statistics, as well as those given by other writers, are very misleading, because it is only within comparatively recent years that syphilis has been so systematically treated as it is to-day, and certainly many of the cases of alleged re-appearance of symptoms many years afterward could be explained on the ground of insufficient treatment. I think that statistics could be collected of the modern methods of treatment of syphilis that would show much more favorably than older statistics.

"WHAT did he strike for?"

"Eight hours."

"What did he get?"

"Three months."—*Judge.*

A Note on Tubercle Bacilli in House Dust.

From *The British Journal*, by R. Shalders Miller, M. B., F. R. C. S. He made an interesting examination of the dust in a house where there had been a series of cases of phthisis.

About fourteen years before the date of making the examination, a man affected with phthisis lived in the house, and left it only a short time before his death. After this an old lady lived in the house for six years, and died there; but not of phthisis.

Then a family consisting of a lady and five daughters took up their residence there; four of the girls being at school most of the time.

In a year the lady became a victim of phthisis. She lived for three years, and then died of the disease.

During her illness the oldest daughter showed symptoms and signs of this disease, but went away from home for a short time, and then returned apparently well, and has remained so.

A few months after the mother's death the second daughter, who had not long left school, displayed similar symptoms; but on leaving home for a time, fortunately made a complete recovery.

In January, 1892, the third daughter, who had left school only at Christmas, and had been suffering from a severe cold, showed consolidation of the apex of the left lung. This girl was not strong, and having had bronchitis when young, the disease advanced rapidly and soon proved fatal.

On several different occasions specimens of her sputum were stained, and showed an ever-increasing prevalence of tubercle germs. Several samples of dry dust, six in all, were obtained from various parts of her home. Of these six samples, five were ruined in the course of preparation. The one still remaining was scraped off the top of the dining-room door. It showed no fewer than eight groups of bacilli, and one of these groups numbered several hundred germs.

After this the house was fumigated and then vacated.

Similar observations have since been reported by a Paris physician.—*Med. Mirror.*

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE ARCHIVES OF PÆDIATRICS

for May. Dr. P. B. Bennie has a paper on
Growing Pains,

which term he criticises, saying that as his experience increased he made the diagnosis less and less frequently, and found that cases formerly so classified were myalgia, rheumatic fever, occasionally typhoid fever, tubercular arthritis, or adenitis, or some similar disorder in which the pain was so acute that the attention of the patient and friends was attracted to it only.

In many cases a child playing out of doors exhausted itself, and the sharp pains complained of were due to retained products of muscle waste, and readily relieved by favoring the return circulation by elevating the limbs, for a few minutes, and stroking them briskly toward the trunk.

Dr. Charles G. Kerley gives his experience with

Acute Bronchitis in Infants.

A large part of the author's observations was among hospital cases, and the general health had been poor, and called often for the continuous use of cod-liver oil, after recovery from the acute disorder.

The treatment advocated is as follows: Ventilating the sick room and keeping it about 70° F., flannel next the skin, and discarding the universal belly-band; frequent changing of position to avoid hypostasis, bathing with lukewarm salt water, preferably at night.

When dyspnoea, hard tight cough, etc., exists, the author advises a steam spray and the use of a sheet wet in hot mustard water (100° raised to 110°), once daily to wrap the child in.

The author believes the spray, and counter-irritation (by mustard paper, camphorated oil, turpentine, etc.), much more useful than internal medication.

A few drops of castor oil are sometimes used at the outset, or a tablet of 1-10 or 1-20 gr. ipecac, with 1-50 to 1-80 gr. tartar emetic hourly; strophanthus, or whiskey, occasionally for cardiac weakness, and, in cases of restlessness, bromide, chloral, or Dover's powder in small doses.

Dr. Henry W. Berg writes about the

Recent Epidemic of Cerebro-Spinal Meningitis.

The disease is, he says, constantly present in New York; but, during 1893 many more than the usual number of cases appeared. Among the facts of interest noted by him are: That most of the cases occurred in children under five years of age (the rule, he says, in all epidemics); at the time meningitis was most prevalent, pneumonia was also very common, and the diplococcus of pneumonia was one of the most constant of the organisms found in the exudate.

The greater nervous irritability of children is a sufficient explanation for their being more frequently affected than adults. Two members of the same family are rarely attacked, and it is considered safe to treat cases of meningitis in the general wards of hospitals. Bad hygienic surroundings predispose to the disorder, and in other respects the localities infected seem often to have very little connection with each other, a large area of country never being affected, but rather small areas, wards or parts of wards in a city, etc.

In describing the symptoms of the disease the author divides them into—those due to the poison of the disease; those due to inflammation of the cord and its membranes; those due to inflammation of the brain and its membranes.

Cases may die in a few hours, or days, or may last some time, and perhaps recover with serious sequelæ.

Pains in the muscles, etc., occur here as in other fevers; also vomiting, so that the pathognomonic symptom is the cervical rigidity, which may by a jolt or start become a true tonic spasm.

Headache is usually present, so also is fever; but either may be absent, and the author reports a case dying without a temperature at any time above 100°.

The only symptom the author lays unusual stress on is the nasal catarrh, he regards this as a probable explanation of the disease, the patient becoming infected through the nasal passages, and a meningitis developing, owing to the pneumococcus, instead of a pneumonia, and he thinks that in this we have the reason for cerebro-spinal meningitis following influenza.

Eye lesions, the author found rapid in development, and of serious grade.

Dr. George Carpenter reports a case of "Diphtheria from Decomposing Placenta."

The explanation of the curious title is that two weeks after a careful antiseptic delivery the patient developed fæcial diphtheria, and, as all sanitary arrangements, etc., seemed of the best kind, all concerned were puzzled to account for the trouble, until a commode was opened and found to contain the placenta, badly decomposed.

Dr. John Thomson (Edinburgh) reports a case of a child contracting "Tænia Circumcinerina from a Pet Poodle."

Dr. W. C. Cole, of Jacksonville, Ill., describes a case of "Fatal Diphtheria in a Child, Contracted from a Chicken."

THE SANITARIAN,

for May, contains an article by Dr. Wolfred Nelson, on

Dangerous Practices on the Isthmus of Panama.

The writer states that it is customary to hire a coffin to carry a corpse to the place of

burial, where the body is removed and buried wrapped in its shroud, and the coffin taken back to the undertakers. Another plan is to rent a burial niche in a building of stone, and so long as this rent is regularly paid the coffin is undisturbed, but as soon as it is overdue "an eviction is in order" and the coffin and contents dumped in a pile, which is burned when its size becomes too great. Still another plan seems to be to reopen a grave and bury another body in it as often as possible; the author having a record, showing that a certain cemetery had been dug over four times in five years.

Other articles in this number are: H. W. Wiley, on

The Adulteration of Food,

in which the author uses the saying of Barnum, that "Americans like to be humbugged," as showing one reason why food adulteration is permitted to continue. The author thinks people would frequently rather pay a higher price for an adulterated food sold as pure and of high grade than for the same food sold with the statement that it is an imitation of a really pure article which sells at a price still greater. On this principle he thinks we may explain the reason why persons not directly interested in their sale do not seem eager to have such articles as oleomargarine stamped with a distinctive name when exposed for sale.

The author speaks of adulterations, which make the article sold less useful as food, although not of necessity injurious, and those that are imitations of a more expensive but not necessarily more nutritious or more palatable food.

Very interesting notes are given of the different state laws on adulteration, misrepresentation, etc., of foods, the manner in which these are enforced, and also of the fallacious ideas people in general have of what the most common adulterations are, and to what extent they are carried out. Mention is also made of the uselessness of laws against adulteration which do not provide for careful inspection of samples, and constant supervision by government inspectors.

Under the title

The Need of a National Health Service,

the petition of the American Medical Association for the establishment of a Department and Secretary of Public Health is given and discussed at length. The objects to be attained by this department are shown to be not only the prevention of contagious and infectious diseases, but also the supervision of certain industries so as to prevent, or lessen, the occurrence of such nervous troubles as writers' and telegraph operators' palsy, mental disorders of overworked mail clerks, and many others.

From the *Nineteenth Century* is taken an article on "Women as Inspectors."

The article refers to women as members of committees of poor-house inspectors, and shows the result of experience in England in this line. Women are certainly more competent than most men to decide whether the bedding and household utensils are in good

condition, and whether or not certain household duties are properly attended to, and since their admission as members of certain boards great improvement has followed their suggestions and supervision.

THE VIRGINIA MEDICAL MONTHLY

for May. Dr. Joseph A. White contributes a paper on

Foreign Bodies in the Air-Passages;

(nose, pharynx and larynx). In speaking of foreign bodies in the nose and the frequent ineffectual attempts made by the unskilled to remove them, the author says there is no need of anxiety about a foreign body being in the nose, nor of these clumsy attempts to extract them. There is no immediate risk nor danger from its presence, and no occasion for hurry about removing it, if one has not a knowledge of the proper methods and a suitable instrument to use. As a rule there is even no discomfort. The only possible dangers are that a small smooth body might, under some circumstances, be drawn through the nostril, and, by a sudden inspiration, pass into the windpipe; or a rhinitis, sometimes of an offensive character, be set up by any lengthened retention of some foreign bodies. Any physician can easily remove foreign bodies from the nose, even when apparently tightly wedged. A spray of a solution of cocaine will sometimes shrink the tissues sufficiently to loosen it, and gentle traction with a bent probe remove it. The nasal douche, properly used from the nostril opposite the one containing the foreign body, frequently brings it out in the flow of warm water.

In regard to foreign bodies in the pharynx the author states that their removal is an easy matter unless they have passed down to the lower third or into the oesophagus out of the domain of the air-passages. A weak solution of cocaine will relieve all the uncomfortable symptoms.

Foreign bodies in the larynx are more serious than in the nose or pharynx, because of imminent danger of suffocation, if it is not speedily removed, or of secondary troubles from its retention that might cause death. The plan followed by the author is to deaden the pharynx with a 2-per-cent. solution of cocaine by a spray-producer, and then apply a 20-per-cent. solution very thoroughly to the larynx with a brush. He has never been able to do away with the reflex spasm of the larynx with a weaker solution, and sometimes he has had to repeat this application several times in order to do this. In this way he has removed pins, bones, etc., from the larynx without any discomfort to the patient. Sometimes foreign bodies can be successfully removed from the sub-glottic space in the same way. Usually, however, when it has passed into the trachea, if the method of inversion fails, or is impracticable (and it usually is only useful when the foreign body has weight enough to be acted on by gravity, such as a coin), tracheotomy becomes necessary. Even if a small body, such as a grain of corn, or some such substance, has passed into a bronchus, it may be coughed out,

when the trachea is opened, in the first rush of air. If it is not thus expelled, many devices are suggested to remove the foreign body, after tracheotomy, but they may or may not be successful. Its retention in a bronchus may be followed by tolerance for awhile, and subsequently expulsion, of which there are many cases on record; or inflammatory troubles may supervene that will cause death sooner or later.

Poisoning by Illuminating Gas

is the title of a paper by Dr. John W. Shaw. The author believes that it poisons in three different ways:

First. By the gas replacing, to a greater or less extent, the atmospheric air, consequently reducing the supply of oxygen.

Second. By the direct poisonous properties of the heavy and light carburetted hydrogen, when mixed with air and absorbed through the lungs.

Third. By the collection of carbon dioxide in the body for the want of sufficient interchange of gasses necessary to remove it.

Which of these plays the most important role in destroying life, the author is unable to say, but he believes that the retention of effete material generated in the body itself is the principal poisoning agent; in reality it is poisoning from the effects of carbonic acid gas, and not illuminating gas. In the treatment the author does not think the inhalation of oxygen has any advantage over a plentiful supply of fresh air. The author thinks that transfusion of blood, when practicable, would be the most rational form of treatment in extreme cases, for it immediately supplies the system with hæmoglobin, of which it is in such great need. This, combined with fresh air, artificial respiration and stimulants, in the form of hypodermic injections of nitro-glycerine, constitute the principal points in treatment.

Dr. Llewellyn Eliot discusses

The Treatment of Hemorrhoids by Injection.

The author reviews the various forms of hemorrhoids and the treatment of them by palliative measures. External hemorrhoids may be relieved by the use of laxatives with the application of an ointment or suppository of extract of belladonna and opium, leeching, or a strong wash of tannic acid. Incising and turning out the clot, or a ligature applied, he states, is the generally adopted form of treatment. With internal hemorrhoids palliative treatment is much more unsatisfactory, though many cases are relieved for long periods of time by the use of laxatives, astringent injections, dilatation of the sphincter, and regulation of the diet and avoidance of alcoholic liquors. When hemorrhoids depend upon any disease of the uterus, an examination should be made, and any displacement existing be corrected before operative treatment is instituted. Hemorrhoids occurring during pregnancy sometimes demand operation; and while the pregnant state is not a barrier, it is safer to defer operation until some weeks after delivery. If internal hemorrhoids actually exist, palliative treatment will not cure them; operative treatment

alone is what should be adopted. Before any treatment for internal hemorrhoids is adopted it is absolutely necessary that the bowels should be well cleansed. This may be done with calomel, sulphate of magnesia or an enema.

The author then proceeds to review the various methods of operating—the ligature, the clamp and cautery, injection of carbolic acid, crushing, excision, dilatation of the sphincter, and Whitehead's operation. Of the treatment by ligature he says that it is the easiest of performance and safest in its results, and is generally accompanied with less pain than any other treatment. Excision is the operation for the expert only. Whitehead's operation is difficult, tedious, and bloody; and if primary union does not ensue, pus accumulates and makes an ugly result. It is therefore applicable to only a few cases. Dilatation of the sphincter muscles cures not so much from the dilatation, but from the fact that it puts an irritable sphincter at rest, for usually there is some abrasion about this muscle. In this condition great relief is felt by its employment.

In regard to the treatment by injection, the author says that notwithstanding all the testimony which has been brought forward against the method, he has never had a bad result from its employment. In every case where he has injected hemorrhoids, there has been a cure as permanent and positive as any result may be called a cure; the hemorrhoids have, as an invariable rule, disappeared, nor has there been a single recurrence of the tumor. The formulae for the injection which have given him the most satisfactory results are: carbolic acid in glycerine and water of a strength of 12, 15, 33, 50, 95 per cent. To inject hemorrhoids it is necessary to draw them well down, using cocaine anaesthesia if desired; as the sphincter is well dilated this is an easy matter. The needle, not too fine or too sharp, is thrust into the pile and the solution driven in. The author has never limited the injection to a few drops, and has always injected all the tumors at one time. The pain is sometimes great, requiring morphia. Vaseline is freely used and the tumors returned to the bowel. Bleeding has never occurred. A slough forms in three or four days, and is cast off, when there will be found a clean surface with no evidence of a pile. In the cases which the author has treated, rarely has it been necessary for the patient to remain in bed more than twenty-four hours. Usually they are about their rooms sooner.

Dr. Joseph Jones contributes a paper on

Diphtheria.

the full title of the contribution being: "Personal Experience with Reference to Diphtheria in New Orleans, La., 1863-1894, also Progress of Discovery with Reference to Nature and Treatment of this Disease During the Past Twenty-five Years." In a former number of the journal the author gave a history of the disease as it has appeared at New Orleans and in this communication he confines himself to points of practical interest as to its origin, hygienic and therapeutic treatment. The author states that he has observed

certain facts which have led him to attribute the propagation, if not the origin of diphtheria, to the filth engendered by milch cows, and also to their milk, in dairies confined to the limits of the city. In support of this view he gives several cases from his records. He also states that he has witnessed cases of diphtheria in which there was no obstruction of the respiration by the diphtheretic membrane, but in which death seemed to result from the direct action of the poison on the heart, and the consequent prostration of the muscular and nervous systems.

The author believes that the Klebs-Loeffler bacillus is the causative agent of diphtheria, and that systemic infection by the diphtheretic poison is not produced directly by the entrance of the microbe into the circulation, but by the ptomaines which have been produced by it. He also states that the use of corrosive sublimate in this disease is not new as it was prescribed by Dr. Tappan in 1880-61. The author states that he cannot subscribe to the large doses and almost reckless manner in which this drug is used. On the other hand, the use of the sulphite and hyposulphite of sodium, in doses of one or two scruples every two hours, both as local and constitutional treatment of diphtheria, appears to be far more philosophical, and should be extensively employed and thoroughly tested.

Dr. W. E. Todd calls attention to the "grave evil that confronts us"—the medical profession—in a paper on

Proprietary Medicines.

The writer says: "Medical journals are more to blame for patents and proprietary frauds than the men who read them. With few exceptions, the journals are living from patent medicine pap, and that is why they are slow to raise their voices against the crying evil. I can name hundreds of the vilest patents that are lauded by reputable medical journals for their superior medical properties and their palatableness, when the publisher knows them to be arrant frauds. No wonder upwards of four hundred so-called medical journals can thrive in the United States." The author urges on the doctors of the land to write their own prescriptions and use staple drugs instead of trusting to patent and proprietary preparations.

Dr. C. E. Busey contributes a paper on

Can Phthisis Be Prevented?

The author believes that tuberculosis can be inherited and that a tuberculous mother can infect her fetus with the bacillus present in her own system. In such cases hygienic measures will be of no avail, except possibly to so improve the general health of the child as by the physical vigor thereby established to eliminate the inherited germs of disease from the system. Beside the well-known precautions against infection from the sputa of phthisical patients the author can suggest nothing except the forbidding of marriage between persons who are susceptible to the attacks of the bacillus of tuberculosis by reason of their family history, until they shall have

arrived at perfect physical maturity. This, the author concedes to be impossible.

Dr. Wm. A. Thom, Jr., contributes a paper on

Chronic Bright's Disease.

with special reference to the causes which produce it. After reviewing the causes of the disease as usually stated in the text books, the author states that he is of the opinion that mind strain from work, worry or sorrow, is a more prolific cause than all the rest. The author's theory is that the kidneys are the emunctories of the brain. The brain, in a constant state of exalted activity, requires the elimination of a quantity of phosphates so largely increased from the normal twelve parts per thousand as to become a "form of injurious matter." All of this work being done by the kidneys, they are then put to a strain under which they slowly break down and take on chronic inflammation and disintegration until they become useless. This action, which the author imputes to the phosphates, would be exactly analogous to that of the urates in the gouty causation of the trouble. The author thinks that this theory would, in a great measure, account for the increased frequency of the disease in late years. In support of this theory the author quotes a case, reported by Dr. E. G. Janeway, of a broker who has had trouble with his kidneys for years. It has been ascertained that when the patient's mind is at rest, albumen tests result negatively, while even the exertion of reading a newspaper will cause albuminous reaction at once.

In regard to the treatment, the author thinks that hygienic measures promise more than others. If alcohol is the cause, abstinence from alcohol; if gout, the treatment of the gout; if the too frequent and great elimination of the phosphates, the avoidance of the causes which excite the mind or call for mental labor. Under all circumstances the most careful attention to the functions of the skin and bowels, avoidance of exposure to cold and dampness, and the enforcement of rest. The author has had more success from the use of bichloride of mercury than any other one remedy, though he cannot explain its action. Chloride of gold and sodium may also be useful since it is a tonic, produces sweating and salivation without the mercurial soreness, and is eliminated by the kidneys, where its curative action makes an impression on the connective tissue, and lessens or prevents its overgrowth. In cases where the uræmic symptoms cause emergencies, pilocarpin is probably our best remedy, on account of its rapid action on the skin, but it must be watched for fear the great salivation may become an obstruction to breathing. In this condition, chloroform and chloral are also useful.

Varicocoele

is the title of a paper by Dr. Stuart McGuire. In regard to the treatment of this condition, the author is of the opinion that the milder forms should be met by palliative treatment only. The mental impression should be combatted by judicious encouragement and

the exciting cause of the trouble determined and removed, if possible. The constitutional tone of the patient should be improved by regulating the habits of life, the use of cold shower baths, and the administration of iron, quinine and strychnia. The scrotum should be supported by some mechanical device, such as a well-fitting suspensory bandage. These measures usually give relief, and may result in a permanent cure.

The author has employed the following operation in five severe cases, with uniformly good results: The scrotum, pubes and thighs are shaved, well scrubbed with soap and water, and irrigated with a bichloride solution. The vas deferens is isolated and slipped behind the other constituents of the cord, and the veins grasped and made prominent by the fingers and thumb of the left hand. An incision about an inch long is made over the cord parallel to its course, and the veins, covered by their sheath, exposed. By means of an aneurism needle, a catgut ligature is passed around the aneurism at the lower angle of the wound, and securely tied. The veins and their fascia are then freed from the surrounding parts for an inch or more above the ligature, and a second ligature passed around them at the upper angle of the wound, and tied. The ends of both ligatures are left long. The portion of the veins between the two ligatures is divided above and below, about a quarter of an inch from the ligatures, and removed. One end of each ligature is threaded on a needle, and passed through the end of the stump which it encircles, and is thus made to emerge at a point opposite the knot. After all bleeding is checked the two stumps are brought together and kept in accurate contact by tying the corresponding ends of the upper and lower ligatures together. The ends of the ligatures are cut short, the wound irrigated and dried, and the incision closed. The next step is the curtailment of the scrotum. The testicles are pushed up against the pubes, and the scrotum drawn through the blades of the scrotal clamp. The clamp is applied from above downward, and care should be taken to depress it well towards the perineum, and to have the raphe of the scrotum in the middle line of the condemned tissue. Interrupted silk stitches are now passed through the scrotum on the distal side of the clamp, and the redundant tissue cut away. The clamp is then removed, bleeding arrested, the stitches tied, and a dressing applied.

In none of the author's cases were there any complications, and the average duration of confinement to bed was ten days.

Dr. J. I. Darby discusses

The Treatment of Traumatic Epilepsy,

reporting several cases. The author states that the only remedies to be relied on in the treatment of traumatic epilepsy are the trephine in depressed fractures and the scalpel in other traumatisms which may produce reflex irritation of this character, and when the bone is removed in fractures, the dura should be opened, and if the cortex of the brain shows any signs of injury, it should be

carefully cut away. When the bone is not cut away in small bits, it may be replaced in the opening and expected to cause no trouble, provided the button is not thicker than the surrounding bone. After surgical operations for this disease, the patient should be kept on medical treatment for at least two years to prevent a return of the trouble, and it is in this class of cases that we may expect good results. Bromide of potash, in full doses, has given the best results, but a solution of bromide of gold and arsenic has of late given very satisfactory results. The patient should be induced to live a temperate and systematic life, sleeping regularly, eating moderately, and keeping his digestive and excretory organs in a healthy condition. Especially is it necessary for him to abstain from the excessive use of tobacco and alcoholic stimulants.

The author urges on surgeons to prevent these cases by operating on all depressed fractures as soon as seen.

Under "Clinical Reports" there appears the report of a "Series of Twenty-five Abdominal Sections," by Dr. I. S. Stone. One death occurred, due to operation for long-standing pelvic suppuration. In this case the death was apparently due to the action of the ether given. Not a single ounce of urine was secreted during the twenty-four hours that the patient lived after the operation. The autopsy revealed a perfectly satisfactory state of the peritoneum, pedicles, etc. The time of the operation did not exceed forty-five minutes.

Dr. A. W. Bolling reports "A Unique Case of Twin Child-birth." There was an interval of thirty-six hours between the births of the two children, during which time the woman remained free from pain. The second child had been dead in utero for some time, as it was putrid. The woman recovered without any complications.

Dr. S. Walter Woodyard reports a case of "Spina Bifida; A Cure by Iodine Injections."

The remaining papers in this issue are:

"A Study of the Soil in Relation to Health and Disease," by George M. Kober, M. D.
 "Outerbridges Wire Cervical Dilator for Obstructive Dysmenorrhœa," by Alexander Irvine, M.D.

"The Evolution of Empiricism in the District of Columbia," by J. S. McLain, M.D.

For Neuralgia.

For stubborn neuralgia try the following:

R Antipyrine.....	3 jss.
Caffene.....	3 ss.
Ext. Cannabis Ind.	
Ext. aconite.....	ss gr. ijsa.
Hyoscyami hydrobromat.....	gr. ½.

M. Ft. caps. No. xxx. Sig. One every two or three hours.

Elixir Five Chlorides.

R Corrosive sublimate.....	3 grains.
Solution chloride arsenic.....	3 drachm.s.
Hydrochloric acid, dilute,	
Tinct. iron chloride.....	ss 1½ ounces.
Ammonia chloride.....	3 ounces.
Elixir simplex.....	to make 16 ounces.

M. Sig. Teaspoonful after each meal.

—Medical Summary.

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A.M., M.D.

MEDICINE

Prognostic Aphorisms: Albuminuria
(Warren.)

If albuminuria appears in the course of another affection and persists more than four weeks it is to be feared that albuminous nephritis will be induced and be irremediable.

The existence of albumen in the urine with a diminished amount of urea is a sign of bad omen.

There is but little hope if in the course of an albuminuria the urine is excreted in small quantity, especially if the diminution occurs suddenly.

When the suppression of urine is total (anuria) the end is necessarily fatal.

A diminution in retinitis is a favorable sign.

Amaurosis accompanied with encephalic pain announces a fatal end, imminent and inevitable.

Acute uræmia may cause death in four hours, but, as a rule, in three or five days.

The eclamptic form is less favorable than any other variety.

Microscopic study of the urine by revealing the state of the kidneys is the essential basis of prognosis.

In acute albuminuric nephritis the disappearance of hydrops without corresponding disappearance of albumen in the urine is of grave portent.

Accidents are imminent if the abundance of albumen coincides with the diminution of the amount of urine.

Bright's disease is always fatal.

Scarlatina in its decline, accompanied with thoracic and cerebral complications due to the existence of albuminuria, is of grave outlook.

The same is true of albuminuric anasarca following measles.

Phthisis and bronchial dilatation are hastened in their course by the appearance of albuminuria.

It is one of the most terrible complications of scrofula and tertiary syphilis.

Erysipelas following in the course of albuminuria is almost always irremediable.

If in the course of a suppurating hematocèle or some other chronic affection albuminuria appears the end will be accelerated.

Albuminuria often determines abortion or premature child-birth. If the child is born alive it often dies several days after of eclampsia.—*St. Louis Med. and Surg. Journal.*

Some of the New Hypnotics for the Insane.

Dr. Granger, in a paper read at a meeting of the New York Neurological Society, said that those drugs were the best hypnotics, which act first and strongest upon the cortex, dulling the sensibilities and lessening voluntary muscular activity, and which influ-

ence but little the vascular system and blood pressure. Among the newer hypnotics he mentioned bromal hydrate; he said it was more dangerous than chloral and of but little value. Chloralamid he considered less depressing than chloral, although serious collapse had followed its use. It produces quite refreshing sleep, with no unfavorable after effects. It is not so certain in its action as chloral, and it does not act so promptly. The dose is from 30 to 45 grains. It is useful as an alternative to the other hypnotics. Chloral-ammonium, in doses of from 15 to 30 grains, is said to be non-depressive, and considered a good hypnotic. Hypnal has the reputation of uniting the analgesic effects of antipyrin and the hypnotic effect of chloral. It is useful when sleeplessness and pain are combined and the employment of opium is contraindicated. The dose of the drug is from 15 to 30 grains. Urethan, which belongs to the ethyl group, is useful in the milder cases of insomnia and for purposes of change. Its dose is from 20 to 40 grains. Somnal is an alcoholic solution of chloral and urethan, and of little value. The dose of somnal is 30 grains. Paraldehyde cannot be classed among the newer drugs. It is the only drug, aside from chloralamid, which is comparable with chloral in hypnotic power. These three hypnotics are valuable in all cases of insomnia. Sulphate of dubolsin is used as a substitute for hyoscin. It has been said to give more natural sleep and to be less depressing. Sulphonal, tetronal and trional are so closely related that they may be considered together. The first mentioned has marked hypnotic power and seemed, in ordinary doses, to be safe. Its long continued use was, however, dangerous to health. Its action is often slow; it seems to be precipitated in the stomach unless quickly absorbed. Its effect is frequently long continued, the second dose often acting better than the first. It appears to be of little value where sleeplessness is associated with pain. Trional and tetronal are true hypnotics, but alike in many respects to sulphonal. They are all less powerful than chloral.—*Occidental Med. Times.*

A New Cure for Hay Fever.

Fuber, of Hamburg, who suffered a great deal from hay fever during the summer, noticed that in winter a coryza was accompanied with hot ears, which regained their normal temperature when the discharge from the nose was established. He tried a reverse order of things on the hay fever, and rubbed his ears until they became red and hot. It is now the third summer he has led an endurable existence. As soon as there is the least amount of fullness in the nose, the ears are noticeably pale. A thorough rubbing of the ears has always succeeded in freeing the nasal mucous membrane from congestion. The rubbing must be thorough and repeated.

Air Embolism.

In the nineteenth of a course of lectures delivered by Dr. David W. Cheever, Professor of Surgery in Harvard University, and published in the *Boston Med. and Surg. Journal*, we find the subject of air embolism treated of substantially as follows: One of the most distressing and rapidly fatal accidents that can occur in a venous wound is the entrance of air. It must be a large vein to admit it. It is sucked in in inspiration. That is the case in the larger veins about the neck, which have no valves, and is especially the case when the mouth of the vein happens to be held open after it is cut by being attached to a fascia, as about the neck, in the popliteal space, in the groin, etc., but especially in the neck. When, for example, the surgeon is engaged dissecting out a tumor in the subclavian triangle, everything is done more easily if the parts are on the stretch. They are out of sight and very probably displaced by the growth of the tumor. The vessels may be enlarged as well as displaced by the long-continued growth.

Bromide of Gold and Arsenic.

Some months ago a physician of this city claimed to have discovered or invented or introduced a new solution of the bromides of gold and arsenic, published some remarkable cases as cured by the administration of the new medicine and secured a wide notoriety with the aid of some injudicious friends. Shortly after a firm of dispensing chemists in the east secured from this physician a monopoly of its manufacture, and advertised it to the medical world by circulars and pamphlets. The profession is under a great obligation to Mr. Bachmann for the publication of the working formula for the manufacture of this solution. We believe Mr. Bachmann to be the originator of what may be called its revival, and of course he speaks *ex cathedra*. This publication effectually exposes the trade secret which has allowed of a monopoly in manufacture, and puts the preparation within the reach of any skilled pharmacist. The advertised solution is sold for one dollar an ounce. The cost of the ingredients in a gallon of it is less than five dollars, leaving a profit of more than one hundred and twenty dollars on every gallon. If it is as therapeutically valuable as is claimed (which we doubt) Mr. Bachmann has conferred a lasting benefit upon us.—*Pittsburgh Medical Review*.

Treatment of Eclampsia.

Tarnier (*Journ. des Sages-Femmes*) maintains that eclampsia represents a true poisoning of the blood. It is not caused by retention of urea or carbonate of ammonia in the blood. In eclampsia the blood is absolutely poisonous, as experiment has shown. On this account Tarnier holds that blood must be abstracted in a case of puerperal eclampsia. But then the patient would have less blood (and loss of blood is a great evil under the circumstances); and that blood would be as

poisonous from the first as the blood removed. Hence the advantage of a milk diet, which is, to a great extent absorbed, so that the blood becomes diluted, increasing in bulk, with diminution of the proportion of poisonous material. Free purgation is also desirable for ensuring elimination of poison. Tarnier gives croton oil. Inhalations of chloroform are also beneficial; they calm the nerve centres, which are excited by the circulation of poisonous blood, and thus check, in a direct manner, the tendency to convulsions.—*Brit. Med. Jour.*

For Whooping Cough.

In whooping cough try the following:

R	Ammon. bromide.....	3 ij.
	Fl. ext. chestnut leaves (Tilden's) ..	3 j.
	Tr. belladonna	3 ss.
	Syr. tolu	3 ij.
	Syr. sim.....	q. s. ad 3 iv.

M. Sig. Teaspoonful every two or three hours.

Ulcerative Endocarditis.

At a meeting of the Biological Society, M. Etienne reported a case of ulcerative endocarditis, which appeared to be due to the bacterium coli. The blood of the heart and of the spleen, collected six hours after death, inclosed the bacillus.—*La Tribune Medicale*.

SURGERY.**Suppurating Buboec.**

Dr. A. Cavazzani, of Venice, recommends the following powder as a dressing after the incision of suppurating buboes:

R	Iodoform.....	3 ivss.
	Salicylic Acid,	
	Subnit. Bism.....	ss 3 ij.
	Pulv. Camph.....	3 ss.

M.

The advantages he claims for it are: 1st. It prevents shrinking of the edges of the wound, so frequent with iodoform, and which so greatly retards cicatrization. 2nd. It rapidly deterges the wound and almost completely suppresses suppuration. 3d. Under its influence the inflamed and tumefied glands rapidly diminish in size, and granulations spring up in abundance, in consequence of which cicatrization is greatly hastened. In many cases where suppuration has been slow and the glands have been inflamed a long time, it is well to curette after the pus is evacuated, but this is not often necessary.

Pontan treats suppurating buboes by puncturing the tumor, allowing the contents to escape, then injecting a ten per cent. mixture of iodoform and vaseline. He claims cure in six to eight days.

Cystitis.

Dr. Dana praises the action of 5-drop doses of thuja occidentalis every three hours.—*Food*.

Gelsemium is said to be beneficial in irritable bladder, especially in hysterical cases.—*Food*.

Operative Treatment of Knee-Joint Disease.

Dr. DeForest Willard (*University Medical Magazine*) says:

Mechanical treatment by rest, fixation, and the use of crutches, either axillary, perineal, or ischiatic, is absolutely essential both before and after operation.

In children under twelve years of age, conservative measures should be carried to the extreme, and all operative procedures should tend to non-interference with the epiphyseal line for as long a period as possible, in order to assist growth of the limb. In these young cases, therefore, tenotomy with subsequent fixation should be the primary procedure, to be followed by erosion when necessary, and by excision only when life is threatened.

From twelve to fifteen years of age conservatism should still be the rule, although the dangers from a shortened limb subsequent to operation are not so serious after growth has been completed. In adults operative treatment should be early and more radical in character, erosion still being preferable to excision, except in very degenerated cases.

Amputation should be employed in children only as a *dernier ressort*; in adults with extensive disease it is often a wise procedure.

The introduction of anti-bacillary substances, both extra and intra-articular, offers hope of retardation in the growth of bacilli, but as yet the procedure is in the experimental stage.

After the subsidence of all inflammatory symptoms the late deformity should be overcome.

- (a) By tenotomy, with forcible replacement.
- (b) By excision; rarely by osteotomy.

Chloroforming in Sleep.

It is becoming fashionable for burglars to chloroform their victims in the hope that their work will be the more easily and effectually done. As the plan is to administer the anæsthetic while the patient sleeps, it is no wonder that failure attends the effort. Happily it is one of the most difficult feats to accomplish, requiring the greatest care and the highest degree of skill. By many good observers it has been claimed to be impossible. The latter may be looked upon as the rule, especially with novices. Before primary insensibility is obtained the victim awakes from the irritation of the inhaled vapor, when force is necessary for the completion of the purpose. In the meantime the alarm may be given and the assailant may be captured. Fortunately the chances are always against the latter, as his victim, facing the horror of strangulation, is instantly and almost instinctively roused to desperate resistance. Taking all the chances, however, chloroform in the hands of a burglar should be considered as dangerous to its victim as a club, an axe, or a bullet, and its administration should be punished to that extreme limit of penalty which is due to the employment of the other murderous measures.—*Medical Record.*

PATHOLOGY.**Gonorrhœa in Women.**

Carry (*Lyon Medical*), has made extensive researches amongst prostitutes and fallen women of other classes, suffering from a vaginal discharge. In only one-third of the number was the gonococcus of Neisser detected. Carry insists that the gonococcus is absolutely specific of gonorrhœa. It is very easy to recognize, being quite different in form from any other microbe. In four out of five cases its seat was found to be the urethra, in one in five the cervix. The periurethral follicles, the vulvo-vaginal (Cowper's) glands, the vagina, and anus are exceptional seats of the gonococcus. Gonorrhœal urethritis in women is the almost exclusive source of gonorrhœa in man, and the absence of discharge, pain, and local tenderness all tend to hide the source of contagion.

ARMY AND NAVY.

CHANGES IN THE U. S. ARMY FROM MAY 13, 1894, to MAY 19, 1894.

Leave of absence for four months, on surgeon's certificate of disability is granted Major Van Buren Hubbard, Surgeon.

Leave of absence for three months, on account of disability, with permission to leave the Department of Texas, is granted Captain Alonzo R. Chapin, Assistant Surgeon.

NEWS AND MISCELLANY.**State Board of Medical Examiners of New Jersey.**

OFFICE OF THE SECRETARY, No. 319 YORK STREET.

JERSEY CITY, May 21, 1894.

A special meeting of this Board for the examination of candidates desiring to practice medicine in this State will be held in the Capitol, at Trenton, on the third Tuesday of June, (the 19th), and it will be the last meeting for the examination of candidates held under our present medical law, as the new law, enacted at the recent session of our legislature, goes into effect July 4, 1894. This new law requires all candidates to have a competent common school education, to be graduates in medicine and surgery which they shall have studied at least four years, and upon which they shall have taken three full courses of lectures, before they can be admitted to the examination for a license, and then all will be subjected to the same examination; it also empowers the Board to accept, in lieu of an examination, the certificates of other State Examining and Licensing Boards, having similar requirements.

Respectfully,
WM. PERRY WATSON, M. D.,
Secretary.